Bayfield Court Operations Limited

Gracewell of Chingford

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Gracewell of Chingford is a care home for 46 older people, some of whom may be living with dementia. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is spread out over three floors. At the time of this inspection there were 45 people using the service.

This care home is run by two companies: Gracewell Healthcare Limited and Bayfield Court Operations Limited. These two companies have dual registration and are jointly responsible for the services at the home.

This inspection took place on 17, 21 and 24 December 2018. The inspection was unannounced. At the last inspection in October 2016, the service was rated Good. This inspection was prompted by an increase in incidents being reported. At this inspection we found the service had met all relevant fundamental standards and remained Good.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Staff were knowledgeable about reporting abuse and whistleblowing. There were enough staff on duty to meet people's needs. The provider had safe recruitment procedures in place. Risk assessments were carried out to mitigate the risks of harm people may face. Building and equipment safety checks were carried out. Medicines were managed safely. People were protected from the risks associated with the spread of infection. Accidents and incidents were recorded, and lessons learnt from these.

People had their care needs assessed before they began to use the service. Staff were supported to carry out their role effectively through supervisions, appraisals and training. People were offered choices of nutritious food and drink and staff were knowledgeable about people's dietary requirements. Staff assisted people to maintain their health. The provider had systems in place for the staff team to share information about people's well-being. The building was tastefully decorated. However, the décor of the building meant some people could have difficulty finding their bedroom. The provider was in the process of refurbishing the building. Care was provided in line with the requirements of the Mental Capacity Act (2005). Staff understood the need to obtain consent before delivering care.

People and relatives thought staff were kind and caring. Staff explained how they got to know people and their care needs. People and their relatives were involved in decisions about the care. Each person had a named care worker who had overall responsibility for their care. Staff knew how to provide an equitable service. People's privacy, dignity and independence were promoted.

Staff understood how to provide a personalised care service. Care plans were personalised, contained people's preferences and were reviewed monthly. People were offered a variety of activities to meet their social needs. Care plans included people's communication needs. The provider kept a record of complaints and these were used to make improvements to the service. People had their wishes documented for end of life care.

People, relatives and staff gave positive feedback about the leadership in the service. The provider had a system in place to receive feedback about the service from people using the service, relatives and staff so they could use these to make improvements to the service. People, relatives and staff had regular meetings, so they could be updated and give their views about the development of the service. The provider had quality audit systems in place to identify areas for improvement. The service worked in partnership with other agencies to make improvements to the service.

We have made one recommendation about the refurbishment of the building.

Further information is in the detailed findings below.

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 remains safe. People felt safe using the service. The provider and staff knew how to respond to safeguarding concerns.

People had risk assessments carried out to mitigate the risk of harm to them. Building and equipment safety checks were carried out.

There were enough suitably qualified and experienced staff employed to meet people's needs.

Medicines were managed safely. People were protected from the risk of the spread of infection.

The provider had a system to record accidents and incidents.

Is the service effective?

Good

The service remains effective. People's needs were assessed before they began to use the service to ensure the service could meet people's needs.

Staff were supported to deliver care effectively through training opportunities, supervisions and appraisals.

Staff spoke positively about communication within the staff team. Healthcare professionals spoke positively about joint working with the service. People's nutritional and healthcare needs were met.

The premises were tastefully decorated. However, some people could have difficulty finding their bedrooms.

The provider and staff knew what was required of them to work within the Mental Capacity Act (2005).

Is the service caring?

Good

The service remains caring. People thought staff were caring.

Staff were knowledgeable about people's care needs.

The provider involved people and relatives in decisions about care.

Staff understood how to provide an equitable service.

People's privacy, dignity and independence were promoted.

Is the service responsive?

Good

The service remains responsive. Staff understood how to deliver personalised care.

Care plans were detailed, personalised and contained people's preferences.

People's communication needs were met.

People were offered a variety of activities.

The provider had a system in place to record and handle complaints.

Care records included people's end of life care wishes.

Is the service well-led?

Good

The service remains well-led. There was a registered manager at the service.

People, relatives and staff spoke positively about the management of the service.

The provider sought feedback from people, relatives and staff to identify improvements that could be made.

People, relatives and staff had regular meetings, so they could be updated on service development.

The provider had various quality audit systems in place to check the quality of service provided.

The service worked in partnership with other agencies to identify areas for improvement.

Gracewell of Chingford

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted by an increase in incidents being reported. This inspection took place on 17, 21 and 24 December 2018 and was unannounced. One inspector and an expert-by-experience visited the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience had personal experience of caring for an older person with dementia.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection, we looked at the evidence we already held about the service including notifications the provider had sent to us. A notification is information about important events which the service is required to send us by law. We also contacted the local authority with responsibility for commissioning care from the service to seek their view about the service.

During the inspection, we spoke with eleven staff which included the director of operations, registered manager, deputy manager, administrator, activity co-ordinator, maintenance person, the chef, two senior care assistants and two care assistants. We also spoke with six people who used the service and seven relatives. We observed care and support provided in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. We reviewed six people's care records including risk assessments and care plans and reviewed four staff records including recruitment and supervision. We looked at records relating to how the service was managed including staff training, medicines, policies and procedures and quality assurance documentation.

Good

Is the service safe?

Our findings

People told us they felt safe using the service. Comments included, "Oh yes, I don't think about that", "Yes, very safe, I know them [staff], I like them. [Staff] have done a lot for me", "I do feel safe here it is a nice place to be" and "I feel safer here than at home after three falls." Relatives also told us the service was safe. Two relatives said, "Oh yes, we would say, very safe." Two other relatives stated, "Yes definitely safe."

The provider had safeguarding and whistleblowing policies which gave staff clear guidance on the actions to take if a person using the service was being abused. Staff had received training in safeguarding adults. The management knew how to handle safeguarding concerns and had appropriately notified the local authority and CQC.

Staff were knowledgeable about the actions they would take if they suspected abuse.
One staff member told us, "I would report it to my manager straight away and obviously document it as well. You can report to head office, the council, CQC." Another staff member said, "You can whistleblow to the company or to the local authority or CQC." A third staff member told us, "I will call my manager as part of the procedure and raise an alert and it needs to be investigated. There has to be action taken, it has to go to safeguarding. Whistleblowing is when you see a wrong doing and you can phone, write anonymously to the home manager, the deputy, it can be CQC." This meant the provider had systems in place to protect people from the risk of abuse.

People had risk assessments carried out to mitigate the risks of harm they may face. These included risk assessments for skin integrity, malnutrition, choking, bedrails and mobility. One person had a risk assessment for weight loss and poor nutrition which included, "I am at high risk of poor nutrition. I am under the dietitian and my nutritional support team to manage my risk factors. I require fortified diet, food supplements and monitoring of fluid intake/weight loss throughout the day. Weigh me every week to monitor for weight changes which will need to be reported to my GP." This meant the provider took steps to mitigate the risks of harm to people.

Staff told us they had access to sufficient moving and handling equipment to enable them to support people safely. Regular equipment checks were carried out. For example, moving and handling equipment had been serviced on 15 August 2018 and wheelchair safety checks were carried out every month, were up to date and any issues identified were signed off when rectified.

Building safety checks were carried out in accordance with building safety requirements. For example, the gas safety check was carried out on 5 January 2018 and portable electrical appliances were tested on 12 October 2018. The fire equipment had been inspected by an external contractor on 14 February 2018 and the service had regular monthly fire drills.

The provider had a process in place for recruiting staff that ensured relevant checks were carried out before someone was employed. New staff had undergone criminal record checks to confirm they were suitable to work with people. The provider had a system to obtain regular criminal record updates to check the

continued suitability of staff. Staff had produced confirmation of their legal entitlement to work in the UK, proof of their identification and had provided written references. This meant a safe recruitment procedure was in place.

There were enough staff on duty to meet people's needs. Two people told us there were enough staff on duty to meet their needs and one other person told us staff responded in a timely manner when they pressed the call bell. Records showed there were eleven staff on duty during the day working with people and five staff on duty at night.

Staff confirmed there were enough staff on duty. A senior carer explained that when people's needs changed requiring more input from staff, they talked to the deputy manager about increasing the levels of staff. This staff member gave an example of a change in a person's needs and told us, "So, a lot of changes were made, and more staff put on." We observed people were responded to in a timely manner when they required assistance. This meant there enough staff on duty to meet people's needs.

The provider had a comprehensive medicines policy which included clear guidelines to staff about medicine administration, ordering and receiving stocks of medicines and record keeping. Senior staff administered medicines. Two care assistants known as 'med techs' were also fully trained to administer medicines. People's medicines were stored in locked cabinets or trolleys in a locked room on each floor. Staff checked the temperature of the room and the medicine fridges daily and these were within the recommended range. Some prescription medicines were controlled under the Misuse of Drugs legislation to prevent them being misused, being obtained illegally or causing harm. The provider had effective systems in place to ensure controlled drugs were stored appropriately and correctly accounted for in line with current legislation.

People who required 'pro re nata' (PRN) medicines had detailed guidelines in place. PRN medicines are those used as and when needed for specific situations. The provider kept a record of medicines in stock. We checked the amount of medicines in stock against the records and found these were correct. Medicine administration record (MAR) sheets had been completed and signed with no gaps which indicated people had received their medicines as prescribed.

Covert medicines are those that need to be given in a disguised format because the person lacks the capacity to understand why the medicine is needed. Guidelines were in place for people who required their medicines to be given covertly. The guidelines contained pharmacy advice on the best method to disguise the medicines and were signed by the pharmacist. This meant medicines were managed safely.

People were protected from the risks associated with the spread of infection. During the inspection we noted the premises were free from malodour. Records showed staff received training in infection control. Staff confirmed they were provided with sufficient amounts of personal protective equipment such as gloves and aprons. There were adequate handwashing facilities available including hand soap and paper towels. The provider employed domestic staff to keep the premises clean.

Records showed the provider documented accidents and incidents. The registered manager gave an example of how lessons were learned at the service. They told us they identified during a quality audit that staff were not engaging with people during mealtimes and people were being rushed. This was discussed and shared with the staff team. The actions taken to resolve the issue included staff from the kitchen now served the food which enabled staff to sit and eat with people. Staff now show plates of the meals on offer to people at the point of serving to help them decide what they would like to eat. This meant the provider had a system in place to learn lessons and make improvements.

Good

Is the service effective?

Our findings

People told us they were happy with the care they received. One person told us, "Yes, very much, everyone is very friendly. [Staff] do enough for me." Relatives told us staff had the skills needed to care for people using the service. Two relatives told us, "Definitely at this level [person] would tell people if she was not happy. [Person] is very well looked after." Another relative said, "I think so, as to their knowledge of my [family member] and his condition."

People's needs were assessed before they began to use the service and important information about the person was captured to ensure the service could meet their care needs. The assessment was comprehensive and included background information about the person's culture, religion and sexuality. Care records documented which aspects of care the person needed assistance with and which aspects they could manage independently.

Staff told us they were given regular training and they found the training useful. Training records showed staff received training in key topics including moving and handling, falls prevention, dementia and fire safety. The training matrix showed the provider when staff were due to complete a refresher training and showed the percentage of compliance with completion of training courses for each staff member.

New staff completed induction training which included shadowing more experienced staff members and face to face training in safety related topics such as first aid and moving and handling. As part of the induction, staff completed the Care Certificate. The Care Certificate is training in a set of standards of care that staff are recommended to receive before they begin working with people unsupervised. This meant people received care from suitably skilled and qualified staff.

The provider supported staff with regular supervisions and annual appraisals. Staff told us they found these meetings useful. Records showed topics discussed during supervisions included, performance, workload, training and development and working relationships. Appraisal records showed the staff member's level of competency was reviewed and the staff member put together a personal development plan of the goals they wished to achieve over the next year. This meant staff were supported to deliver care effectively.

People were assisted to meet their nutritional needs and had a choice of nutritional food and drink. Kitchen staff and care staff were knowledgeable about people's individual dietary requirements and preferences. The kitchen was well stocked with a variety of nutritious food. Fridge and freezer temperatures were checked twice daily.

During the inspection we observed lunch and dinner being served. Each table was nicely dressed and contained condiments. We saw people were offered fruit squash, water or a glass of wine to have with their meal. People were shown plates of the choices of food on offer and were offered three courses for both the lunchtime meal and the evening meal including fruit as an option for dessert.

The provider had a system in place for staff to receive updates on people's well-being and changes in care

needs. These updates were given twice a day through a handover between day staff and night staff. Staff told us this system worked well and important information or changes could also be found on the communication page of the computer system.

The service had systems in place for effective joint working with other agencies. A visiting healthcare professional who came to the home twice a week told us, "Coming here is like a family. They are so caring from the management to the cleaner. The communication is there, is established. The way they interact with the patients [people using the service], it's fantastic." Another visiting healthcare professional said, "[The care service] is exceptionally top of the range, the way they treat the residents [people using the service]. The staff are very supportive to us. They are doing everything well and they manage their health and safety and infection control, so they should keep it up."

People were supported to maintain their health. Care records showed people had access to healthcare professionals as required including the GP, district nurses, optician, dentist and optician. Staff confirmed they escorted people to their healthcare appointments.

The building was laid out across three floors which were accessible by a lift. People's bedrooms were personalised. The home was tastefully decorated and well furnished. However, the décor of the building was confusing to people with dementia or poor eyesight as the floors, walls and bedroom doors were the same colour throughout each floor. This meant it was difficult for people to find their bedroom. The management told us there were plans to refurbish the building including the main lobby area. These plans included placing memory boxes on the wall area next to people's bedroom doors.

We recommend the provider seek advice and guidance from a reputable source about refurbishing the home to meet people's needs.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. At the time of this inspection, there were 10 people with legally authorised DoLS and 31 people awaiting a decision because they required a level of supervision that may amount to their liberty being deprived. Records showed assessments and decision-making processes had been followed correctly.

The provider had a consent policy which gave clear guidance to staff about their responsibilities under the MCA. People or their legal representative signed a form to consent to their photograph being taken and to consent to receiving care when they began to use to the service. Staff were knowledgeable about MCA and DoLS and understood the need to obtain verbal consent before delivering care. For example, one staff member told us, "There isn't a time you don't ask permission. At the end of the day it's about what they want not what I want." This showed the provider had systems in place to work within the requirements of MCA and DoLS legislation.

Good

Is the service caring?

Our findings

People told us staff were caring. One person told us, "They [staff] are very nice, very friendly." Another person said, "Yes, they [staff] are very good. They help you as much as they can." A third person said, "Staff are very good, very friendly, I have friends here, very sociable here." A relative told us, "I would say [caring], yes, staff are always cheerful."

The provider had a system of recording compliments received. For example, a relative sent a thank you card which stated, "My heartfelt thanks to you all for the wonderful care and kindness you devoted to [person using the service] during her stay at Gracewell especially during the last six months when life was not so good for her and she needed special care. You do an amazing and often challenging job and it was a comfort to know that [person] was in such good hands."

Staff described how they got to know people and their care needs. One staff member told us, "I looked at and read their care plans and dependency. Some of them have a 'life story'. You talk, you listen. I like to create relationship with people and you get the best result. If my approach is not working, I can go to my colleague and say will you approach 'cos mine did not work. I may ask their family." Another staff member said, "Before they actually move we do a home assessment. I do the assessments as well. We relay the information to the staff and we do the care plan on the system. We get the information from the person and the next of kin. As they come in you are speaking to them." A third staff member told us, "I go straight into their care plan. I look at their sexuality, their preferences. We need to take more time and have a chat with them." This meant care was provided to people by staff who knew what assistance they required.

During the inspection there was a calm, relaxed and happy atmosphere throughout the home and people were supported at their own pace. For example, one person indicated they would like to go into the garden. A staff member supported the person and did not rush them when the person stopped by the Christmas tree in the garden lounge. We observed this staff member engaged in conversation about the decorations and waited until the person was ready to continue into the garden. The person smiled indicating they enjoyed this interaction.

People and their relatives were involved in decisions about the care provided. Relatives confirmed they had regular communication from staff at the home. Comments included, "Yes, we have regular meetings" and "Yes as I am here every day." The service had a 'keyworker' system where each person using the service had a named person who had overall responsibility for their care. The registered manager told us, "We phone the family regularly and [staff] check the wardrobes and bedrooms. We have a 'resident of the day' system which coincides with the care plan review. We incorporate that [the 'resident of the day' system] with hairdressing and the activity person. We have made the care a lot more person-centred."

Staff explained how people using the service made choices about the care they received. One staff member told us, "By offering them choices. Bath or shower, how they want to wear their hair, which bag, which shoes, if they want make-up today." Another staff member said, "I do [promote choices]. Some has chosen to have their glass of wine with their meals and we respect that." A third staff member told us, "I keep telling the

team you can't just go into the lounge and tell them, 'everybody's having tea'. You go into the lounge and you need to ask them. We have residents who like wine or Guinness. Let them enjoy what they want and they will be happy. I tell the girls [staff] 'Don't rush them'."

The provider had an equality and diversity policy which gave guidance to staff about providing an equitable service. Records showed staff had received equality and diversity training. The registered manager told us, "We accommodate everybody. The only thing we have to make sure of is that we can meet their needs."

Staff knew how to treat people equally. A staff member said, "I do treat everyone as an individual because everyone is different." Another staff member told us, "Treating everyone as an individual and giving everybody the same opportunities." A third staff member said, "We are all aware we live in a diverse community. We're all unique, we are all different. You try to be as fair as possible."

The registered manager explained how they would support people who identified as being lesbian, gay, bisexual or transgender (LGBT). The registered manager told us, "When we do the pre-admission, we incorporate [sexual identity] in the care plan. We accommodate personal relationships and respect privacy." The registered manager explained there were people using the service from the LGBT community and they accommodated partners.

Staff explained how they supported people who identified as being LGBT. One staff member told us, "I think the first thing you have to do is respect their sexuality. I always tell people to educate themselves. I respect everybody." Another staff member said, "You treat everybody equally anyway. Just offer the same opportunities and make them feel welcome. If any other resident says anything just explain to them everybody is the same and to keep their opinions to themselves." A third staff member told us, "We have examples within the home [people identifying as LGBT using the service]. We don't discuss near other residents. Confidentiality policy is very tight. It's the person's right and choice to be what they want to be." This meant staff were aware of equality and diversity.

People's privacy and dignity were promoted. The provider had a policy which gave guidance to staff about promoting people's privacy and dignity. We observed staff knock on doors before entering people's bedrooms. One staff member told us, "Privacy is important in care. I like to have a conversation with resident. I tell the girls to make sure they are ready with everything they need. I make sure the door is closed. Take a towel, [private parts] has to be covered. A towel has to be wrapped around them." Another staff member said, "When you go in to do personal care make sure the door is closed. Try to not let other people know you are focussing on the person, take them away quietly. You need to protect the resident at all times." A third staff member told us, "We provide choice and we respect dignity. We always knock the door before we go into person's room. We close the door when we are providing personal care. If offering toilet, I make sure I am close [to the person]; I don't shout across the room."

Staff described how they promoted people's independence. One staff member told us, "That is the best thing to let them be independent. I tell the girls they need to read the care plans to see where they [people using the service] are independent. Ask them before doing anything for them." Another staff member said, "Try to get them to help themselves as much as they can, like for example brushing their teeth, encouraging them to walk or eat by themselves for as long as possible." A third staff member told us, "It's about encouragement. It's about providing choice. Supporting people and working with them to gain the skills." This meant people were assisted to maintain their independence.

Good

Is the service responsive?

Our findings

Staff understood how to deliver personal care. One staff member told us, "I think it is treating everybody as an individual. Not to treat everybody the same." Another staff member said, "Providing care to that person as an individual. Each person likes things done separately and differently. Some people like to go to bed at different times or get up at different times." A third staff member told us, "Some may want female care, so we provide that."

Care plans were personalised, detailed and contained people's preferences. One person's care plan stated, "I love talking and enjoy 1:1 time with people. Please do not rush me and be patient. Encourage me to express my creativity by asking me about my interesting life. I love talking about the things I have done." Another person's care plan stated, "I prefer mixed sex company. Invite and encourage me to attend activities that promote engagement with others." People's care plans were reviewed monthly and relatives confirmed they were involved in their family member's care plan reviews. This meant staff understood how to provide personalised care.

We asked the registered manager what they had done to implement the Accessible Information Standard (AIS). The AIS requires providers to evidence that they record, flag and meet the accessible communication needs of people using the service. The registered manager gave an example of how they supported one person with a sight impairment. They said, "We did laminated pictures to identify [person's] mood and [for] actions like the toilet which [they] can point to which one [they] want. We can give audio information." The registered manager explained how they supported people with a hearing impairment, "Firstly, we will identify whether they have a hearing aid in good working condition. We would identify if they can lip read, we show them two plates [of food to choose]. We would use writing."

People's communication needs were recorded in their care plan. For example, one person's care plan stated, "Always speak to me in my language of choice which is English. I need to be reminded to wear my glasses when I am up. Ensure my glasses are clean, free from scratches, and in good repair. Involve my family in arranging eye test for me when needed." This meant people's communication needs were met.

People told us they enjoyed the activities offered. One person told us, "I play cards, they do quizzes and I do colouring in, they give the colouring in to me." Another person said, "Yes we get a programme each week of activities and we can join in or not." A third person told us, "Oh yes, you can more or less do what you like, enough to do." A relative said, "[Person] likes listening to music, does 'listening to music' activities which she enjoys, likes hand massages."

We spoke with the activities co-ordinator who described the variety of activities on offer. There were monthly events which included "the captain's table". Photographs showed this event included the creation of a luxurious cruise atmosphere for five people using the service set with classical music playing and the kitchen staff dressed as waiting staff serving the food. The head chef prepared a grand three course menu separate to the weekly menu and the table set to a fine dining standard. Records noted that all the diners expressed how delicious the food was and one person said they did not know what they had done to

deserve such a treat. Photographs of the diners showed the diners enjoyed the captain's table experience by the joyful expressions on their faces.

The weekly activity programme included music and movement, hairdressing, physiotherapy exercise, arts and crafts, memories and music, colour therapy and board games. The activity co-ordinator told us a volunteer from a local church visited weekly to give people holy communion. Records showed there were cheese and wine sessions and outside entertainers came in at least twice a week. We saw a live violin concerto was booked to visit on Boxing Day and there were plans to serve sherry.

The activity co-ordinator told us they had plans to introduce new activities to the programme. The plans included inviting a person from outside the home to run a bible study class and prayer sessions, introducing twilight activities so that relatives could become involved, bird watching, a regular library trip or a visiting library for people to obtain books to read including audio books and a regular book club so that people could discuss what they were reading.

People's care records contained an activity care plan so that staff would know what interested the person. One person's activity care plan stated, "Inform me of trips that are planned and let me choose which ones I might enjoy, I like to use the mini bus but I might criticise the driving. I love listening to music and enjoy playing on the piano. I have no spiritual needs and prefer not to participate in any religious or spiritual activities." We noted there was a piano in the service and a weekly session where people could choose to play on the piano. The above meant people's social and religious needs were met through the activities offered.

People and their relatives told us how they would make a complaint if they were not happy with the service provided. One person told us, "If any complaints I'd tell my family and they would speak to [person at] the desk." Another person said they would complain to, "Person at the desk, whoever is in charge here." A third person told us they would complain to, "The Nurse in charge." Two relatives told us, "We would ask for the manager. Do not actually know the manager so would ask at reception." Another relative said, "Usually complain to deputy manager. I can take it further to head office. [I've] not [complained] to head office. Usually sorted by deputy manager. Dealt with satisfactorily."

Staff were knowledgeable about how to deal with complaints. One staff member told us, "If they want to make a complaint I do listen to them. I will take them to a quiet place and write it down. I will try to reassure them and if not I will hand it over to the manager. If it is a big one the managers do get involved." Another staff member said, "There is a complaints procedure and everyone has the right to make a complaint. I will ask if they like to make the complaint to me or to someone else. I will take it to my manager." A third staff member told us, "Give them the complaints policy and refer them to the manager."

The provider recorded complaints and actions taken in order to make improvements in the service provided. There was a complaints policy which gave clear guidance to staff about the actions to take if they received a complaint. We reviewed the record of complaints and saw 12 complaints had been made during 2018. Records showed one complaint was in the process of being investigated and the rest were dealt with to people's satisfaction. This showed the provider had a system in place to deal with complaints.

The provider had an end of life care policy which gave clear guidance to staff on how to support a person at the end of their life. Staff knew how to support people who were at the end of their life. Care records included an advanced care plan which included the person's preferred place to be at the end of their life. We noted that some people had a proactive elderly persons' advisory care plan (PEACE care plan) which is a type of advanced care plan. This is an anticipatory care plan for people living in care homes approaching the

end of their life which is shared with health professionals including the hospital and is signed by the person's doctor. The aim of a PEACE care plan is to help avoid unnecessary or unwanted hospital admissions for the person when they are at the end of their life as well as enabling the care home to provide care in line with the person's wishes. This meant people's end of care preferences were documented.

Good

Is the service well-led?

Our findings

There was a registered manager at the service. Relatives spoke positively about the management of the service. One relative told us, "I mainly deal with deputy manager. There have been changes since [person] has been here. Different managers, different staff. It's been settled for a while now." Two relatives told said, "The deputy manager is good, but we haven't spoken to the manager. We could ask to see her but mainly deal with the deputy manager. She is brilliant."

Staff told us that colleagues from different ethnic and religious backgrounds were treated equally. For example, one staff member said, "People are so friendly, and it makes a difference. They are very inclusive. It works both ways."

Staff spoke positively about the management of the service and confirmed they felt supported to carry out their role. One staff member told us, "Both the managers, [registered manager and deputy manager], they have always supported us. I do think [registered manager] is a good leader. She always puts the residents first. I am amazed with the support I have received." Another staff member said, "Oh yes I do feel supported. I know [registered manager] is a good leader because myself, I would not want to work with a manager who would not work with us. With my two managers they will take my call anytime."

The registered manager described the variety of ways in which staff could air their views about the service provided. They said, "We have a 'town hall' meeting [staff meeting] where staff can voice out any concerns any suggestions, anything they want to talk about. We have daily 'huddle' meeting [heads of department meeting] where we discuss what happened the day before, what is happening today and what is happening the day after. We do have an open-door policy where staff can come into us, they don't have to wait, where we can talk about it and work out solutions. We do supervision. We have appraisal. Once a year the company has a 'voice count' survey for staff and an outside company analyses them and sends in the result."

Staff told us they had regular meetings and they found them useful. One staff member told us, "I do find them [staff meetings] very useful." Another staff member said, "Yes. It is useful. Everyone brings their points and they [management] act on it."

We reviewed the 'town hall' meeting minutes from October 2018 and noted a representative from the Alzheimer's Society had visited to talk about their activities in the local area and dementia. Other topics of discussion included home refurbishment, maintenance, staff recruitment, water temperatures and training.

Daily 'huddle' meetings were held at the service and records showed these were up to date. Heads of departments attended these meetings and discussions included a summary of call bell response times, hospital admissions, completion of charts, appointments and birthdays.

Quarterly health and safety meetings were held within the home. Topics discussed in the most recent meeting held in December 2018 included risk assessments, training in health and safety topics, fire drills,

moving and handling, personal protective equipment (gloves and aprons) and contractors working on site.

The service held monthly clinical governance meetings. Records of these meetings showed that discussions were held around the home's computerised recording system which included a breakdown of accidents and injury, dependency levels of people using the service, infections, medicine errors and safeguarding.

The provider had a system of holding regular meetings for its home managers. The minutes of the most recent meeting held in December 2018 showed topics of discussion included the dining experience, care, recruitment and meetings to be held within each home.

The provider had a system of carrying out regular surveys to capture the views of people using the service, relatives and staff. The registered manager told us people and their representatives were now encouraged to leave their views on an internet survey site. The provider analysed the comments and reviews placed on this website. We observed the comments were positive and the service had received a score of 9.6 out of 10 which had been calculated from 22 reviews placed by people using the service, relatives and friends. We noted the results of the 2018 staff survey showed that 93% of staff were proud to be associated with the provider.

The provider had a system of holding quarterly meetings for people using the service and for relatives. We reviewed the minutes for the most recent meeting held for people who used the service in August 2018 and saw the topics discussed included refurbishment of the home, room service, drinks for visitors and the Bistro café. Topics discussed in the most recent relatives meeting held in October 2018 included refurbishment of the home, staff recruitment, activities, menus and dementia. The registered manager told us they planned to combine the meeting for people using the service and relatives to encourage increased attendance.

The registered manager carried out a daily walk around the service to identify areas for improvement. Records were up to date and showed that during the walk around, the registered manager checks included all staff named on the rota were on duty, sufficient staff were rostered for the night and the following day on each floor, the premises were clean and in a good state of repair, call bell response times, care charts were completed and the dining experience.

Call bell audits were carried out daily following the daily 'huddle' meeting and the registered manager carried out an analysis and signed them if there were no issues. We checked the audit for 23 December 2018 and noted all call bells had been answered during the previous 24 hours within one minute.

The provider carried out regular support visits. We checked the report for the visit carried out on 15 November 2018 which noted the new dining room was up and running and just awaiting new flooring. We noted this was ticked off as now complete and we observed the new flooring was in place.

The provider also carried out regular care audits and monitoring visits. We reviewed the audit carried out on 21 August 2018 and saw checks made included completion of the paperwork, staff knowledge about safeguarding, staff rotas, supervisions, call bell audits, personal emergency evacuation plans, meetings, care plans, diet notifications and the dining experience for people using the service. We noted no issues were identified during this audit.

The service worked in partnership with other agencies in order to make improvements. The registered manager told us, "The Alzheimer's Society came here to the relatives meeting and they are going to invite us to events. Avon House school from Woodford High Road, came for a carol service. The local nursery are coming to sing. We do attend the Waltham Forest forums. We have someone from Co-operative funeral to

talk to people once a year. Some residents go to the memory café in Chigwell."