Unique Help Group Limited

Whitstable Nursing Home

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Good**

Overall summary

The inspection visit was carried out on 03 December 2014 and was unannounced. The previous inspection was carried out in May 2014, when non-compliance had been found with three regulations. This inspection included following up the action taken by the service in response to the non-compliance. The inspection was brought forwards because of concerns raised to the Care Quality Commission (CQC) from an anonymous source, in regards to people's general care and welfare.

The premises are an old detached building situated near to the seafront of Whitstable. The service provides nursing care and accommodation for up to 34 older people, some of whom may also be living with dementia. The accommodation is provided on two floors, with most bedrooms on the ground floor. On the day of the inspection, there were 27 people living in the home, with one admission during the day, taking the total to 28 people.

The service is run by a registered manager, who was present on the day of the inspection visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Some of the people in the home had been assessed as lacking mental capacity to make complex decisions about their care and welfare. There were clear records to show who their representatives were, in order to act on their behalf and in their best interests, if any difficult decisions needed to be made about their care and treatment.

All staff had been trained in safeguarding adults, and discussions with them confirmed that they understood the different types of abuse, and knew the action to take in the event of any suspicion of abuse. Staff knew about the whistle blowing policy, and were confident they could raise any concerns with the manager or senior management. Senior managers visited the home on a regular basis, and three visited the home on the day of our inspection. Staff knew that the senior managers were accessible to them.

The service had suitable arrangements in place to protect people from assessed risks. These included risks of fire, and other risks such as trips and falls, legionella and use of equipment. Each person living in the home had individual risk assessments based on their own personal care and treatment. These included a Personal Evacuation Emergency Plan (PEEP) in the event of fire or other emergency. Other risk assessments were in places for people's individual needs.

The manager had systems in place to determine the numbers of staff needed in relation to the dependency needs of people living in the home; and the overall numbers of people living in the home at any one time. She told us that she was able to increase staffing levels if people's dependency needs rose significantly, and used bank staff who were known to the home for additional shifts. However, it was evident that care staff were very busy and appeared to be rushed, and people were left unattended in the lounges for periods of time, especially people living with dementia. The service could not demonstrate that sufficient numbers of staff were employed at all times to meet people's assessed needs.

You can see what action we told the provider to take at the back of the full version of this report.

There were reliable recruitment practices in place to check that staff were suitable for their job roles. Staff showed kindness, empathy and patience with people during our inspection. People said that the staff "Looked after them well" and responded quickly when they called for assistance. Staff were supported through individual supervision meetings, group supervision, regular training, formal training qualifications, staff meetings, and yearly appraisals. All staff were trained in dementia care.

People's medicines were administered by trained nurses. These were stored and managed in accordance with current guidelines and legislation.

People told us that they liked the food, and had plenty of choice. The menus provided a suitable range of foods to meet people's different nutritional needs. The catering staff were familiar with different diets, such as fortified diets for people with low weight, and diabetic diets. Staff took time to assist people with eating and drinking where necessary.

People's health care needs were assessed and managed by trained nurses, in association with other health care professionals. Referrals were made to GPs, and to other health care professionals as needed, such as dieticians, speech and language therapists, dentists, and the mental health care team. People's care plan records contained detailed information about their health and personal care needs. People's preferences were clearly recorded, and staff showed that they were familiar with these, such as calling people by their preferred name.

The premises were visibly clean. However, the premises did not provide an environment that facilitated the care of people with nursing needs and/or dementia. For example, the main lounge was long and narrow, which meant that chairs could only be placed around the room. The paintwork and walls were painted in light colours to increase the lightness in the property, but there was a

Summary of findings

lack of pictures or signage to aid and stimulate people with dementia; and a lack of activities to meet their assessed needs. An activities audit showed that this was in the process of being addressed.

We recommend that the staff follow the guidelines provided by the National Association for Providers of Activities for older people (NAPA); and the National Dementia Strategy for England (in association with Alzheimer's Society), to support the staff in providing a suitable range of activities for people living with dementia to enjoy.

Staff were aware of people's preferences to stay in their own rooms or to socialise with others. The activities co-ordinator carried out individual time with people during the mornings, which was enjoyable for the people concerned, but meant that other people were left without any activities or stimulation apart from watching television or having music playing. Group activities were carried out during most afternoons, but on the day of our visit some people said they were tired after lunch and did not wish to join in. Staff enabled people to go out of the home, and some had recently visited the town's cenotaph to celebrate Remembrance Sunday.

People said that staff were friendly, and a relative said "The staff are pleasant and welcome me when I come in. They do their best." One of the people told us "I am very settled being here"; and another said "I am as settled as I could possibly be with having had to leave my own home." Personal care was given in the privacy of people's own rooms or bathrooms; and suitable screening was available for people in shared rooms. Two people's dignity was compromised during the day, as one person was wearing someone else's clothing; and another person was weighed in the lounge in view of other people.

You can see what action we told the provider to take at the back of the full version of this report.

People told us that if they had any concerns they would talk to the nurse on duty, or the manager or her deputy. They were confident that if they raised any concerns they would be dealt with appropriately. Formal complaints had been responded to in a timely manner, and except for one complaint which was ongoing, had been satisfactorily resolved.

The manager had been in post for eighteen months, and staff told us that she had brought about positive changes in the home. This included more liaison with staff about bringing in changes, and allowing staff to take more part in discussing different ideas to improve the home. The company provided on-going support from senior management, which included a visit to the home at least once per month to monitor the quality of the service. However, auditing processes had not highlighted the need for people living with dementia to have more supervision and stimulation available. There were systems in place to obtain people's views and ensure that their views were listened to and taken into account, so as to provide ongoing improvements. The manager was acting as the nurse on duty throughout the day of the inspection, and said she usually worked approximately one shift per week as the nurse. This helped her to maintain first hand knowledge of how care was being delivered.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. Staffing numbers were not sufficient to meet people's assessed needs at all times. However, people told us they felt safe living in the home, and said that staff usually responded quickly when they called for help.

Staff demonstrated a clear understanding of safeguarding procedures and how to raise any concerns. All of the staff had received training in safeguarding people from abuse. Risk assessments were carried out to identify specific areas of concern, and suitable measures were put in place to minimise the assessed risks.

Staff recruitment practices were suitably thorough to ensure staff were suitable to work in their job roles. Nursing staff administered people's medicines and followed the Royal Pharmaceutical Society guidelines for medicines management in care homes.

Is the service effective?

Requires Improvement

The service was not consistently effective. Staff were familiar with people's individual needs, and had received essential training. They were encouraged and supported in studying for formal qualifications. However, although staff had been trained in dementia care, there was a lack of evidence that staff knew how to apply their training and support people living with dementia.

Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). They applied this training in supporting people who lacked full mental capacity, ensuring that people were able to take day to day decisions in line with their level of capacity; and arranging best interest meetings for times when they needed help with complex decisions.

The service provided people with a suitable range of food and drink to provide them with a nutritious diet. Staff supported people with eating and drinking as needed. People's health needs were met by nurses and other health professionals who visited the service.

Is the service caring?

Requires Improvement

The service was not consistently caring. Staff were patient and listened to people, and assisted them as needed. However people's dignity was sometimes compromised by inappropriate actions.

People and their relatives were provided with suitable information about the service when people moved into the home. People were involved in their care planning, decision-making and reviews; and were supported by their family members or advocacy when they required this help.

Summary of findings

Is the service responsive?

Requires Improvement 

The service was not always responsive to people's needs. People were supported in planning their care and treatment, and in following their preferences about their day to day lifestyles. However, people were not always supported in carrying out individual or group activities that would provide them with choice about what to do during the day.

People felt confident that they could raise any concerns or complaints, and that these would be responded to appropriately.

Is the service well-led?

Good 

The service was well-led. The manager was easily available to people and their relatives, and supported staff in delivering care.

There were systems in place to monitor the home's progress. These included staff meetings, visits from senior managers, audits and questionnaires. Results were analysed and action was taken in response to people's views and findings from audits. However, the auditing processes had failed to identify that people living with dementia lacked sufficient supervision and stimulation.

Records were stored so as to protect people's confidentiality. They were suitably detailed, up to date, and correctly signed and dated.

Whitstable Nursing 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, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 03 December 2014 and was unannounced. The inspection was carried out by two inspectors. The visit had been brought forwards due to concerns raised from an anonymous source.

Before the inspection we looked at previous inspection reports, and information which providers are required to send into CQC to notify us of specific incidents, serious accidents and deaths in the home. These notifications were in line with those expected from this size of care home. We obtained feedback from a Social Services staff member and from a visiting health professional.

We viewed all communal areas of the home, and some of the bedrooms with people's permission. We talked with 13 people living in the home, some of whom were in their own rooms, and some in lounge or dining areas. Some people were not able to explain their experiences of living in the home to us due to their dementia. We therefore used the Short Observational Framework for Inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We also talked with two relatives and a person's friend who were visiting people; a visiting health professional; seven staff from different job roles, the manager, and three senior staff from the company.

We observed staff carrying out their duties, such as helping people with reduced mobility to move from one area to another; assisting people to eat and drink; and explaining processes to people before carrying out care. We assessed how people's care needs were being met by reading people's care plans and talking with the same people or their relatives.

During the inspection visit, we reviewed a variety of documents. These included: six people's care plans and related documents such as food and fluid charts, three staff recruitment files, staff training records, staffing rotas, staff handover records, maintenance records such as fire safety and daily repairs, environmental and health and safety records, complaints file, providers monthly visits, auditing records including audits for medicines management and infection control, staff meeting minutes, menus, activities plans, and 16 quality assurance questionnaire responses.

The previous inspection was carried out in May 2014. Three breaches in compliance were found. These were followed up during this inspection and the breaches with these regulations had been met.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in the home. They said that they knew that staff would respond when they used their call bells for help, and that staff "usually" responded quickly. This promoted their feelings of safety. Two people told us they felt safe since moving into a residential home where staff were always available. A relative told us, "I feel Mum is safe here, which means I don't worry as much".

Staffing levels were determined according to the numbers of people residing in the home, and the levels of care and input that they required. However, while the staffing levels took account of people's physical needs, they did not show that they promoted people's individuality and provided person-centred care. Staff were visible throughout the day, but the care staff were quite rushed. People said, "They are always busy"; and "The carers are very good, but sometimes they are rushed off their feet". There was one activities co-ordinator who was mostly based in the main lounge during the morning. This enabled him to see if people needed support from care staff. The care staff did not stay in either of the lounges but checked people's safety and welfare when they took other people in or out of the lounge, or when they went through these areas. Care staff were kind and thoughtful, but were busy attending to people's practical needs and sometimes lacked the time to stop and talk with people when they entered the lounges or other communal areas.

The second lounge had two people living with dementia sitting in there in the morning, and other people during lunch and the afternoon. A staff member told us this lounge was used for "People who might be noisy, and upset other people in the main lounge". We saw that staff were not able to spend much time with people in the second lounge, only attending to them for practical needs such as helping them with eating and drinking. However, this had two doors at one end of the lounge, providing a walk through area for staff. This meant that staff were frequently walking through this lounge and observed people's comfort as they walked through. Sometimes during the day we heard people calling out from this lounge, and shortly after our arrival one person called out because they had knocked a table over. The inspectors alerted one of the care staff who attended to the person. The activities co-ordinator told us that he spent most mornings giving individual time to people in their own rooms. This meant that he was not usually available to provide support or stimulation for people in the lounge areas. This showed that the service could not demonstrate there were sufficient numbers of staff on duty at all times to meet people's assessed needs.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us that they understood about different types of abuse and how to recognise if these might be taking place. They said that they would talk to the manager or senior managers in the company if they had concerns that abuse might be taking place. Staff also knew that they could contact the local authority safeguarding team if they felt they needed to do so. Staff had received training in equality and diversity and understood about protecting people from discrimination in regards to their gender, disability, race, beliefs or sexual orientation. Policies and procedures were in place for staff to raise concerns or use the service's whistle-blowing procedures (these enable staff to raise concerns about other staff in good faith, without fear of discrimination).

Environmental records included health and safety checks such as checks for fire alarms and fire equipment; monthly checks for equipment such as hoists and slings; nurse call bell system checks; and checks for wheelchairs and bed rails. Other safety checks included tests for legionella, and tests for hot water temperatures. The manager carried out monthly audits for accidents and incidents, and informed the company about these. The audits showed if there were any patterns developing and if action could be taken to prevent further accidents.

Day to day maintenance concerns were recorded in a book by staff as concerns arose. These included items such as light bulb changes, repairs to thermostats, and painting and decorating. The maintenance person signed to confirm when items had been addressed, and we saw that most issues were dealt with promptly. The home was visibly clean and smelt fresh in all areas.

People's care plans included individual Personal Emergency Evacuation Plans (PEEPs) in the event of needing to move people out of the home in an emergency (for example, a fire). These provided clear details of people who would be able to move independently, those who would need support from one staff member, and people who would need assistance from two staff members and the use of a hoist and a wheelchair. Individual risk

Is the service safe?

assessments were in place to identify specific risks for different people, such as the risk of slips and falls. This included the use of equipment such as hoists and slings for people who needed assistance with their mobility. These showed how risks could be minimised by using the correct equipment for each person, with two staff to support them. Monthly risk assessments were carried out for people who might be at risk of developing pressure ulcers; and preventive measures such as the use of pressure-relieving mattresses and cushions were in use. Body maps were used for recording any bruises and injuries, and these were followed up to assess their healing.

Staff recruitment files confirmed that required checks were carried out before staff commenced employment, to assess their suitability for their roles. These included Disclosure and Barring Service (DBS) checks, and checking people's proof of identity. Any gaps in employment history were explored, and two written references were obtained. Trained nursing staff were required to show proof of their training qualifications and professional registration. The manager told us that interviews were usually carried out by herself and one other senior staff member.

Medicines' management followed safe practices and had clear procedures, in accordance with the Royal Pharmaceutical Society guidelines for the management of medicines in care homes. Medicines were stored in a small clinical room in locked cupboards. External creams and lotions were correctly stored separately from internal medicines. Bottles of medicines and eye drops were dated on opening. This showed the nurses' awareness that these had a shorter shelf life than some other medicines, and made it easy to identify if medicines were going out of date. We did not see any out of date medicines. There were processes in place to provide effective stock rotation.

Controlled drugs (CDs) were stored in a separate CD cupboard and were accurately recorded in a CD register. Some medicines needed to be stored at lower temperatures, and these were stored in a locked drugs fridge. We saw that fridge and room temperatures were checked each day to ensure that medicines were being stored at the correct temperatures.

Medicines were administered by the nurses, from a medicines' trolley. Most medicines were administered using a monitored dosage system whereby each person's medicines had been dispensed separately for each dose, by the pharmacist. The nurse recorded each dose administered in a medicines administration record (MAR chart) for each person. The MAR charts included a photograph of each person to confirm their identity, and highlighted any allergies. The MAR charts contained clear directions for nursing staff, and had been accurately completed to show when medicines had been given.

Requires Improvement

Is the service effective?

Our findings

People said "They look after me very well"; and "The staff are very helpful". Staff knew details about people's individual care needs, and where they wanted to go. All staff had received training in dementia care, but our observations did not confirm that staff knew how to apply this training and support people effectively who were living with dementia. Two people living with dementia were left unattended in a lounge for long periods of time during the morning. The staff acknowledged them as they went through this lounge area, but did not stop and spend time with them or provide them with stimulation apart from the television being on, and giving them drinks. We observed that one person was restless and fidgeted with their cup and their table, and called out from time to time.

New staff worked alongside experienced staff so that they could become acquainted with people's different needs and preferences. The manager told us that new staff were provided with a staff member as a mentor so they "Don't feel lost in the crowd." New care staff completed the Skills for Care 'Common Induction Standards', using a workbook, if they had not previously been employed in care work. (These are the standards employees working in adult social care need to meet before they can safely work unsupervised).

All staff had an induction and a probationary period, and during this time their individual supervision was mostly carried out by the manager so that she could assess their progress. The on-going supervision programme showed that staff had individual supervision with the manager or their line manager at least every two months, or more frequently if there were specific needs for giving people extra support. The records showed that supervision was also carried out on a group basis, so that staff could discuss topics together. Recent examples included supervision with training sessions for people's dietary and fluid intake; reviewing staff's work performance; communication; and the keyworker role and the role of the named nurse.

All staff completed required training as part of their probationary period, and regular training updates were provided. This included subjects such as first aid, moving and handling, health and safety, basic food hygiene, infection control, and safeguarding adults. Additional subjects included training in mental health, dementia, death and dying, the Mental Capacity Act 2005, and the Deprivation of Liberty Safeguards (DoLS). Some of the training was provided through DVDs and training packs, and some was through face to face training. This enabled staff to discuss their training together.

Staff were encouraged to achieve formal qualifications such as National Vocational Qualification (NVQ) /Diploma levels 2 or 3 in care, and the service provided the opportunity and support for staff to achieve this. (NVQs are work based awards that are achieved through assessment and training). Four care staff had recently commenced this training, and the manager said another member of staff had voiced their wish to carry out formal training. A staff member told us, "There is lots of training, and I found the NVQ 3 training was very helpful." Nursing staff were encouraged to develop their skills and knowledge, with subjects such as venepuncture and using a syringe driver (a syringe driver is a small, portable pump that can be used to give a continuous dose of medicines through a syringe, and is often used for pain relief).

People's consent to all aspects of their care and treatment was discussed with them or with their next of kin or representative (as appropriate). Some people lacked full mental capacity to make complex decisions about their care, but were able to make day to day choices such as the clothes they wanted to wear or menu choices. Staff promoted people's independence, but had arrangements in place for supporting people if complex decisions were needed in regards to their care and treatment. This included meetings with their next of kin, representative or advocate, and with health and social care professionals, to make decisions on their behalf and in their best interests. There was no-one in the service who was assessed as needing to be deprived of their liberty for their own safety, although one application for Deprivation of Liberty Safeguards had recently been submitted. No restraint practices were used within the service. Some people had forms for "Do Not Attempt Resuscitation"(DNAR) in their care plan files. These showed if the decision had been discussed with the person or their representative, and had been signed by appropriate medical staff, usually the person's GP.

We saw that people's care files and associated documents included consent forms for taking photographs (for identity purposes, for displaying pictures of events in the home, and for wound care); and signed agreements for each section of people's care plans. We observed that staff

Is the service effective?

obtained people's verbal consent before assisting them with care or treatment, and communicated clearly with people. We heard staff giving clear explanations to people when assisting them with their mobility, for example, a member of care staff said to someone walking with a Zimmer frame, "Your chair is right behind you, so you can sit down now."

People were able to sit in their own rooms, the dining-room or the lounge for their meals. On the day of our visit, no-one chose to sit in the dining area, although this was a pleasant environment, and people were offered the opportunity to sit there. People said that they liked the food, with comments such as, "I really enjoyed my dinner today"; "Dinner was lovely"; "The meals are not bad" and, "The food is lovely and we can choose what we like."

People were offered hot and cold drinks throughout the day, and were assisted by staff where necessary. Drinks were provided in cups or plastic beakers with a spout or straw, showing that staff knew the type of crockery or cups to support individual people. Relatives were able to assist people with their food and drink where they wanted to do this.

The cook on duty showed us the menu choices, and these confirmed that a good range of foods was provided, so that people could have a nutritious diet. The menus were planned on a four week rolling programme. There were two choices for each course of each meal, and people could ask for different items if they did not want the set menu choices. The main meal was served at lunch, and evening meals usually included a hot option as well as a choice of sandwiches, toast or other snacks. The cook told us that the catering staff were familiar with different diets, such as fortified diets for people with low weight, and diabetic diets; and they provided soft diets and pureed foods for people as needed. The cook was very motivated about having completed further training in catering. This meant that she had progressed from being a teatime cook to providing full meals at lunch times, and this demonstrated the company's support for staff to develop their skills in their different job roles. The kitchen was visibly clean and well organised, and had been given a high rating of five (very good) by the Environmental Health Officer.

A nutritional assessment was used at admission to identify people's nutrition and hydration needs. These were reviewed monthly. Food and fluid charts were used to record people's intake where there were any concerns, and these were accurately completed. People were weighed on admission and then monthly for monitoring purposes.

People's care plans recorded their individual health needs and included their past and present medical histories. Assessments were carried out on admission to identify people's specific needs, such as falls risks, moving and handling assessments, nutritional needs, continence care and ability to communicate. The records identified if people needed equipment to support their needs, such as pressure-relieving mattresses and cushions; bed rails and padded sides; and hoists and slings for people who required support with moving from one place to another. Care plans were put in place after the assessments were completed. The nurses recorded people's temperatures and blood pressures each month, and carried out nursing interventions such as wound care, administering medicines, changing catheters, and checking blood sugars. People's records showed when the nursing staff had contacted health professionals such as GPs, opticians, occupational therapists, speech and language therapists, dieticians and the mental health team. A community psychiatric nurse visited a person during our inspection. A visiting health professional told us that the last time they had visited someone in the home that they had made recommendations about the person's care needs. They said that the staff had acted on their recommendations on the same day.

Requires Improvement

Is the service caring?

Our findings

People said that the staff were friendly and helpful, and they felt well cared for. People told us, “I feel very settled here, they look after me very well”; “The staff are very kind and always come if I call them”; and “The girls” (meaning the care staff) “are very good.” Comments on recent questionnaires and letters sent to the home were full of praise for staff. Some of these included, “A big thank you for all the wonderful care you willingly give to my relative”; “Thank you for looking after me, everyone is so friendly”; and “How can I express my gratitude for such wonderful, caring people?” A relative told us “My mum is very happy at the home. Everyone who works here is excellent!”

People said that the staff promoted their dignity by closing bedroom or bathroom doors when assisting them; and using curtains to screen them where people shared rooms. We saw that people’s dignity was compromised on two occasions during the day, which we discussed with the manager and other senior managers during our feedback. A relative told us that the person she was visiting was wearing someone else’s cardigan, and said “She has also been given someone else’s trousers to wear before now.” Another person told us “I do not always get the right clothes back from the laundry. I have a wardrobe full of things that are not mine.” The second occasion was when we observed that care staff weighed a person in the lounge, in full view of other people. Staff asked the person first if it was all right to do this, and told him he had a choice, but he said he did not suppose he really had much choice. This showed that staff did not always protect people’s dignity.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed that staff spoke to people in a kindly and respectful manner, and listened to them without rushing them. People’s preferences were taken into account in regards to their care, such as if they preferred male or female staff to assist them with personal care, and if they preferred a bath or a shower. Staff addressed people by their name of choice, showing that they were familiar with people’s individual preferences. Care plan audits showed that people were involved in their care and were invited to take part in their care planning and monthly reviews.

People were provided with information before moving into the home, and as part of the admission process. This included a service users’ guide, and the home’s complaints procedure. People and their relatives were informed about advocacy services, and were asked if they required support with advocacy at the time of their admission. Advocacy services provide independent support for people when they need help to express their views or to make decisions about their lives. The registered manager told us that none of the people who lived at the home had advocates but they would be supported if they needed to access these services. Mental capacity assessments were carried out if there was doubt about people’s ability to make complex decisions about their care and treatment; and to ensure that they had appropriate support or representation if they needed this.

Visitors were welcome to visit the home at any time, and said that the staff were always friendly and offered them a drink. They were invited to join in with activities and to stay for as long as people wanted them to.

Requires Improvement

Is the service responsive?

Our findings

People's care plans did not all contain clear records to show when people had taken part in activities, how they had responded, and if they had enjoyed them. These records were in the process of being updated. The company had carried out a questionnaire for activities co-ordinators for their different care homes, to identify if activities were based on people's hobbies and interests; and if there was the opportunity for people with different needs to take part in activities. The questionnaire had highlighted some of the shortfalls, such as a lack of sensory activities and stimulation for people living with dementia; and people in their own rooms being without access to the activities programme which was displayed on noticeboards.

An audit of activities had been carried out in November 2014, and an action plan had been drawn up in response to bring about improvements. We saw from activities programmes that these were being implemented, and highlighted the need for more sensory activities for people living with dementia. The activities organiser explained that the staff talked with people at the time of their admission, to find out the sort of activities they liked, and if they wished to be involved with group activities. They gave them a copy of the current activities programme. People told us that there were activities to join in with if they wanted to do so. One person said "I am very settled here, but I like to stay in my own room and read my books." A relative told us, "I know activities take place because my mother tells me so; but I am not usually here at the times they are being carried out." Two other people said, "I like the word games because they get us thinking", and "I like to do group activities twice a week as well as Friday bingo".

Care plans showed if people liked to join in with group activities, or if they preferred to stay in their own rooms. The activities co-ordinator was fairly new in post, and the company's senior activities co-ordinator had arranged to spend the day in the home supporting him and discussing how to develop the activities programme beyond the current range. People were given a weekly activities schedule which included items such as reminiscing, word and picture games, bingo, pamper days, and music or television. Recent activities included topical subjects such as making Christmas cards and Christmas decorations. The environment was not supportive in helping people to feel socially included and able to talk with each other, as the main lounge was long and narrow and chairs had to be placed around the sides of the room. The dining room was often used for group activities where people could sit at the tables. After lunch, people in the lounges were invited to go to the dining room to join in with activities, but many said they were tired and did not want to join in with group activities.

The activities co-ordinator told us that he usually spent time with people individually in their own rooms during the mornings, which helped to prevent people from feeling socially isolated. On the day of our visit he stayed mostly in one of the lounge areas. However, there were usually no staff available to provide activities or stimulating conversation for people in the lounges during the mornings. One of the care staff said, "I know that even if we can spend just five minutes talking with people it makes all the difference to them". Staff told us that one of the two lounges was used mostly for people living with dementia who might become noisy or restless. There were no items in the room to interest them or distract them. The paintwork and walls were painted in light colours to increase the lightness, but there was a lack of pictures or other items on the walls, and a lack of signage to support people living with dementia or short term memory loss to find their way around. The activities audit action plan showed there were plans to display orientation boards to help people living with dementia to be reminded of the date, the day and other details such as the weather.

The activities co-ordinator had arranged for entertainers to come into the home, for example, for music and singing; and arrangements were made to take people out of the home. Three people had recently taken part in a Remembrance Day service at the town's cenotaph. The activities co-ordinator told us that the trip had been offered to everyone, but only three people had chosen to go out. Another trip had been arranged for people to see the town's Christmas tree and Christmas lights. A monthly church service with Holy Communion was carried out in the home for those who wished to take part.

People's care plans included a summary at the front of their files so that it was easy to access the information. They provided a comprehensive picture of the person's previous lifestyle, medical history, and social history. Additional files had been prepared for quick reference, so that staff could find relevant details. These were called 'At a

Is the service responsive?

glance' profiles, and included a 'This is me' form. These forms had been supplied by the Alzheimer's Society, and were especially helpful for recording the lifestyle and preferences fro people living with dementia. They included people's family history and previous employment history, and information such as 'wears glasses', 'can communicate clearly', 'able to make own daily choices', 'prefers to stay in own room', 'prefers female staff for personal care', and 'prefers a bath'. Four of the 'At a glance' profiles we viewed contained thorough details, but two had not been properly completed.

People were involved in their care planning and care plans were reviewed each month. Changes were made in accordance with people's changing needs and circumstances. People and their relatives were invited to be involved in their care plan reviews. People were encouraged to retain their independence, even in small ways, such as 'Encourage her to wash her own face and hands' and 'Likes to eat finger foods'. The files included risk assessments and care plans for different aspects of daily living, such as people's mobility, continence, skin care, personal hygiene, nutrition, and mental capacity. Specific information was provided to give clear directions to the care staff. For example, 'Has restricted mobility and needs a hoist and medium sling for all transfers, with two staff. Has frail skin which is prone to skin tears, so handle carefully'.

Each person had a property list which recorded their personal possessions and items of clothing. This was signed on admission by the person or their next of kin, as well as the manager. This showed that staff recognised the importance of people's personal items and supporting them in their choices of the items they had in their own rooms. The home had a number of shared rooms, and this clarified which items belonged to which people. The manager ensured that people knew before admission if only shared rooms were available. Discussions took place between the people who wished to share, and their relatives or representatives, to check that sharing a room with the other person was their choice.

People told us that they could express their concerns to the manager or staff, and these were dealt with appropriately; except that two people told us they were frustrated with having had the wrong laundry on several occasions. The complaints procedure was on display in the entrance hall, and gave clear directions about how to make a formal complaint. This included relevant names and contact details. People were given a copy of the complaints procedure with other information when they were admitted to the home.

The complaints log showed that the home had had three complaints since July 2013. The records showed that these had been suitably investigated, and the manager had replied to people with the findings from the investigations. The records showed that, where possible, the manager invited people to attend face to face meetings, so that they could talk together about the issues and resolve the complaint. There was one complaint which was still going through formal processes and had not yet been resolved. The person had been invited to talk with senior managers from the company, and the managing director, as part of this process.

We recommend that the staff follow the guidelines provided by the National Association for Providers of Activities for older people (NAPA); and the National Dementia Strategy for England (in association with Alzheimer's Society), to support the staff in providing a suitable range of activities for people living with dementia to enjoy.

Good

Is the service well-led?

Our findings

People told us that they knew who the manager was, and one said "She sometimes brings my medicines." Relatives said that the manager was accessible and they could talk to her any time if they needed to. On the day of our inspection, the manager was working as the nurse on duty. This enabled her to keep up to date with how care staff were delivering care, and to be fully acquainted with people's changing needs. She worked approximately one day per week as the nurse on duty, and on other days another nurse would be carrying out the nursing care, leaving her free for management duties. She told us that she visited the home at weekends so as to be available to meet family members and visitors who could only visit at weekends.

The home had a caring and friendly culture, and made visitors welcome. Staff told us that the manager had brought about positive improvements in the home, with more opportunities for staff to be involved in discussing the home's development. They were able to share their views and ideas through general staff meetings, and meetings for heads of departments. They were encouraged to add items to the agenda, and to join in with discussions. Staff said that they were updated every day at handover meetings, and these often formed the basis for discussions about specific aspects of care for people and how to support them. The staff told us that they had individual supervision sessions every two months, or more frequently if needed. We noted that a new staff member had received seven supervision sessions within three months.

People and their relatives were invited to share their views at any time on a day to day basis, and also through regular residents and relatives' meetings and questionnaires. A resident and relatives' meeting was advertised as due to take place during December 2014. Questionnaires had been sent out in June 2014 and the results had been analysed and displayed on the home's main noticeboard. We saw that overall results were positive, with an overall response of 91% of people satisfied with how the home was running. Questions included, "How would you rate staff friendliness and professionalism?" and "How would you rate the food and drinks served?" There was space for additional comments and some people had added their thoughts. These included, "My relative is contented in the home"; "I have no reason to make any complaints"; and " My relative's needs and demands are met, which stops us worrying."

The manager told us she was supported through visits from senior managers within the same company, and this was evident as three visited the home on the day of the inspection. A senior manager visited the home each month to carry out an independent audit; and a quality assurance clinical manager assessed how people's nursing needs were being met. These managers were also available for advice and support at any time. The manager said that the senior management team had brought in extra insight, and formats for records which had "Helped to take the work forwards". She added that the senior management made managers "Feel supported, and provide very good team work". There were processes in place for a senior manager to oversee the home when the manager was taking annual leave or to cover for any sickness.

Checks were carried out for people's personal monies that were stored on their behalf, to ensure that the records and receipts had been accurately completed and documented. Monthly checks and audits were carried out by the registered manager to monitor the home's progress. Audits were included for care plans, medicines' management, infection control, pressure ulcers, safety and suitability of the premises, staff training and development, housekeeping, and nutrition. Some of the auditing processes had identified actions that needed to be taken, and these had been followed up appropriately, or were due to be carried out. For example, the activities audit had shown that more stimulating or sensory activities should be introduced for people living with dementia, but these had not yet been started, and it was evident during our visit that people living with dementia required more stimulation and support.

The manager was familiar with her role and responsibilities, and notified CQC appropriately of incidents and events. A recent event had been when the heating had stopped working in one area of the home. CQC had initially been informed about this from a separate source, before the manager also informed us. We contacted the manager, but the problem had already been dealt with. The radiators had been fixed on the same day, and staff had used portable heaters and blankets to keep people warm in this area of the home during the repairs.

Good

Is the service well-led?

Records were well maintained, with clear directions and kept up to date, except for activities records which were in the process of being recorded more fully. Records were stored so as to protect people's confidentiality. They were appropriately signed and dated to show who was accountable for their completion.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services People who used services did not always have their dignity protected. Regulation 17 (1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The provider could not demonstrate that there were always sufficient numbers of suitably qualified, skilled and experienced staff employed to meet people's assessed needs. Regulation 22