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Haighfield Care 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This was an unannounced comprehensive inspection and took place on 27 June 2016.

We last inspected Haighfield care home on 30 January 2014, when we found the service to be compliant with all the regulations we assessed at that time.

Haighfield care home is a purpose built, four storey home located on the A49 in Standish, Wigan. Haighfield care home can accommodate a maximum of 45 people. The care home has 39 bedrooms, there are 14 bedrooms with en-suite facilities and four companion rooms. Haighfield care home offers residential, nursing, continuing care, day care and respite care services. Car parking is available at the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014in relation to safe care and treatment and good governance. We also made a recommendation regarding the environment.

People told us they felt safe living at the home. However, we found some practices in the home were not safe. Sluice room doors, which contained various cleaning products, were left unlocked and unattended by staff. We also saw the supplement 'Thick and Easy' left unattended on the medication trolley and in the lounge.

Medicines were not managed safely as we found occasions when prescribed medicines had not been available to people when they needed them.

People had comprehensive risk assessments which were reviewed and updated timely to meet people's changing needs. People and their relatives told us they were involved in assessments and planning of the care and support received.

The home had suitable safeguarding procedures in place and staff were able to demonstrate that they knew how to safeguard people and follow the alert process. Appropriate employment checks had been conducted before new staff commenced employment in the home.

Staff told us they felt supported and received regular supervision and an appraisal of their work. Appropriate training was undertaken but this was in staff's own time and there was some confusion as to the provider support to staff to ensure they were sufficiently trained to meet the requirements of their role.

We saw the meal time experience was not rushed and people were appropriately supported. Everyone we spoke with was happy with the food provided and people were given sufficient amounts to eat and drink to meet their nutritional and hydration needs.

People were supported in line with the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

We observed people living at the home were living with sensory impairment, memory issues or living with dementia. We saw no evidence of dementia friendly resources or adaptations to support people's orientation in any of the communal lounges, dining room or corridors. We have made a recommendation in relation to environments.

People's relatives and visitors we spoke with were also complimentary about the care provided. Staff treated people with kindness and respect. There were two identified dignity champions and people's privacy and dignity was maintained.

We saw staff had attended end of life training and the home was equipped to support people nearing the end of life. There was a dedicated memorial area of the home which contained cards and a memories book.

People were encouraged to maintain their relationships with friends, family and their pets. There were no prescriptive visiting times and friends and family were invited to activities when entertainers where scheduled. People were provided individual and group activities. Everybody's needs were considered and catered for.

People and their relatives knew how to make a complaint. They told us they were confident in the manager and we saw complaints had been resolved in the required timeframes. People were asked for their input in how the home was run through resident meetings and there were suggestions books and boxes in the foyer of the home.

On arrival at the home, we found confidential information and records were not safely secured.

The registered manager was visible throughout the inspection; people, their relatives and staff spoke highly of the home and the management team. Management audits were undertaken but the provider had not implemented an audit system to maintain oversight of the home.

Records we looked at confirmed that CQC had received all the required notifications in a timely way from the service.

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

Not all aspects of the service were safe.

We identified environmental risks as the sluice and kitchen were unlocked and unsupervised. 'Thick and Easy' was accessible to people in the lounge.

Medicines were not managed safely as we found occasions when prescribed medicines had not been available to people when they needed them.

Risk assessments were comprehensive, reviewed regularly and changed timely to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff told us they received training relevant to their role and had regular supervision.

Staff understood the importance of obtaining consent and supported people's rights under the Mental Capacity Act.

We found the home did not have adequate signage features that would help to orientate people living with a diagnosis of dementia.

Is the service caring?

Good

The service was caring

People were treated with kindness, care and respect by staff who promoted their independence.

People's privacy and dignity was respected and promoted.

People were listened to and were supported to make their own decisions and choices.

Is the service responsive?

Good

The service was responsive.

The service employed an activities co-ordinator and the activities programme was tailored to meet individual people's needs to reduce the risk of social isolation.

People and their relatives knew how to raise a concern or complaint and we saw complaints had been investigated within the required time frames.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led

The culture in the home was open and inclusive. The manager was visible and we received positive feedback about their leadership from people, their relatives and staff.

The registered manager encouraged feedback from people and their relatives and conducted regular audits to make sure people were receiving a quality service.

Confidential information was not stored securely.

Haighfield Care Home

Detailed findings

Background to this inspection

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

The inspection was carried out on 27 June 2016 and was unannounced. The inspection team consisted of three adult social care inspectors from CQC (Care Quality Commission).

At the time of the inspection there were 35 people living at Haighfield care home. The home had 39 bedrooms, 14 with en-suite facilities. The bedrooms were located across three floors and accessed by the stairs or lift.

Throughout the day, we observed care and treatment being delivered in communal lounges and dining areas. We also looked at the kitchen, bathrooms and external grounds. We asked people for their views about the services and facilities provided. During our inspection we spoke with the following people:

- Seven people who used the service
- Eight visiting relatives and friends
- Nine members of staff, which included; the registered manager, nursing staff and care staff from the day and night shift.

We looked at documentation including:
- Nine care files and associated documentation
- Five staff records including recruitment, training and supervision.
- 15 Medication Administration Records (MAR)
- Audits and quality assurance documentation.
- Variety of policies and procedures
- Safety and maintenance certificates

Before the inspection we reviewed the information we held about the service. This included notifications

regarding safeguarding and incidents, which the provider had informed us about. A notification is information about important events, which the service is required to send us by law. We also looked at the Provider Information Return (PIR), which we had requested the registered manager complete prior to conducting the inspection. This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

We liaised with the local authority and local commissioning teams and we reviewed previous inspection reports and other information we held about the service.

Requires Improvement

Is the service safe?

Our findings

We asked people and their relatives whether there were any concerns regarding people's safety whilst living at the home. People told us; "I definitely feel safe. The doors are locked at night so you know there won't be any intruders. People are asked to sign in so we know who is in the building." "It's a safe environment I would say. I recognise everybody around the place which is re-assuring." "I've always been very safety/security conscious. I was a victim of burglary at my previous home, so I feel much safer here."

The visiting relatives and friends we spoke with also said they felt their family members were safe. Relative comments included; "The security is very good. People are well looked after and monitored." "It's a safe place for [person] to live. I feel re-assured knowing [person] has bed rails so they don't fall out of bed."

We found some practices in the home were not safe. Sluice room doors, which contained various cleaning products, were left unlocked and unattended by staff. The kitchen area was accessible to people and we saw a hot water dispenser which posed the risk of a scalding incident occurring. We saw razors and cleaning products in bathrooms. We also saw the supplement 'Thick and Easy' left unattended on the medication trolley and there were three tubs of 'Thick and Easy' and a surface cleaner spray on the floor in the lounge. We saw prescribed ensure drinks to fortify people's dietary intake stored in accessible cabinets in communal areas. We found the registered manager was not doing all that was practicable to mitigate the risk to people.

We checked to see that people received their medication safely and looked at a sample of 15 medication administration records (MAR). We found a vitamin B injection had not been administered at the time required because it had not been ordered in sufficient time by the home and two instances were PRN medicines had run out for people who used the service. We found that the registered manager had not protected people against the risk of associated with the safe management of medication.

This was in breach of Regulation 12 (2) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation Safe Care and Treatment because the provider was not doing all that was practicable to mitigate risks and medication was not managed safely.

On the day of the inspection, we saw medication rounds were completed timely. Cream charts were in place and people prescribed creams had a body map in place highlighting where on the body creams were to be applied. People's creams were safely stored in a locked cabinet in people's bedrooms. The nurse explained that care staff supported people's application of creams but nursing staff applied topical creams. We saw blue sheets contained information regarding allergies; fluid, dietary needs and detailed homely remedies people could be given.

During our inspection, we observed a person did not want to take their medicine at the time they were asked. We saw the nurse mix the medicine with the person's breakfast. We looked at the person's care plan and saw that a covert medicine programme was in place, with medicine being added to food if the person refused to take it at the prescribed time. We saw a capacity assessment and meeting had been convened before the covert medicine programme had commenced.

We observed staff use 'thick and easy'. We saw a checklist which detailed the required consistency and we saw staff adhered to this. A relative told us; "I have no concerns with fluid intake, [person] is on thickened drinks and they always get them as they should."

We saw in all the files that we looked at that the home had completed comprehensive risk assessments, which had been reviewed regularly for each person. Risk assessments were seen for; moving and handling, falls, malnutrition, eating, drinking and swallowing, continence, pressure ulcers, and bed rail risk assessments. The risk assessments contained information for staff about minimising the risks to the person. We saw airflow mattresses and pressure relieving cushions were in place as per risk management plans for people that were assessed as needing them. We saw one person was at high risk of falls and on occasions had fallen from their bed. In response to this, bedrails had been introduced to keep the person safe. We saw the service had consulted with the person and sought their consent to the use of bedrails to mitigate the risk.

We saw the home had an up to date safeguarding policy and procedure in place. We saw that the registered manager was following current local procedures and they kept a record of referrals made to the local authority and the investigation outcome. We spoke with staff to ascertain their understanding of whistleblowing and safeguarding vulnerable adults. Staff told us; "Signs of abuse include bruising, being withdrawn or not eating and drinking. I would speak to the nurse in charge and we have contact information for CQC and the police." "Safeguarding is all about preventing abuse. If I saw somebody being punched or kicked that would be physical abuse. I would report it straight to the manager." "I would report any issues to the nurse in charge, plus the manager has an open door policy, there is always someone on hand." "Exposing people to risks, physical, emotional, financial, institutional, neglect. Report concerns to the nurse in charge."

We spoke to the manager who told us that the home holds small amounts of money for some of the people who live there. This is used to buy items from the shop or pay for beauty treatments.
The home had a resident's log book, into which all transactions in and out are recorded. Receipts for all purchases were kept.

People were protected against the risks of abuse because the home had a robust recruitment procedure in place. We looked at five staff files and saw employment application forms, interview questions, proof of identity and employment references. Disclosure Barring Service (DBS) checks had been undertaken before staff commenced in employment. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults. The registered manager was able to demonstrate nursing registrations were up to date and maintained.

We looked at whether the home had sufficient numbers of staff to meet people's needs and keep them safe. During the inspection we saw the registered manager, three nurses and five care staff where able to meet people's needs timely. We ascertained that the service did not use a dependency tool to formally calculate staffing levels but the registered manager told us staffing numbers were frequently reviewed and adjusted to respond to people's choices, routines and needs. The people living at the home told us they felt there was enough staff to support them. One person told us; "There is enough staff here; they always come when I want them." A relative told us; "In the past staffing levels were a bit sparse, but they seem to have addressed this and are fine now." "They are a bit short now and again such as if someone is off sick, but [person] is still well looked after."

We looked at how the home managed accidents and incidents. We saw there was a monthly overview of any accidents that had taken place along with a description of the injuries sustained and any actions that were

taken. Where any incidents or falls had occurred, we saw there was a clear description of any follow up observations and a review detailing the person's progress since the incident.

We noted there was a policy and procedure in place with regards to accidents and incidents and escalating health concerns. This provided staff with guidance such as calling the emergency services, seeking advice from the GP, completing an accident form, informing relatives and to proceed with a review following the incident. The records available demonstrated adherence with the policy.

The registered manager explained that there were only two people living at the home that were mobile due to the building not being safe for people if they experienced any confusion and were independently mobile. We looked at the homes safety documentation to ensure the property was appropriately maintained and safe for the people who lived there. Fire safety checks were completed weekly, with different call points checked on a rota system. Emergency lighting was tested monthly with issues logged and action plans recorded. The home had a fire drill log in place which listed names of all staff that had completed an evacuation. However we saw no record that smoke or heat detectors had been checked on a monthly basis.

Gas and electricity safety certificates were in place and up to date and the fire alarm; nurse call and emergency lighting systems were serviced yearly with records evidencing this. Manual handling equipment met LOLER guidelines, with six monthly checks and service carried out and documented on all slings, hoist and the homes lift. We observed that all rooms had window restrictors in place and that these were checked quarterly.

Good

Is the service effective?

Our findings

A relative of a person using the service told us; "Everyone knows what they are doing and when to do it, it runs like clockwork here, [person] is kept clean and toileted regularly."

We saw there was a staff induction in place, which staff confirmed they completed when they first started working at the home. We saw the induction covered; fire, safeguarding, food hygiene, health and safety, mental capacity act (MCA), medication, moving and handling and equality and diversity. Staff told us; "I was able to work closely alongside other staff to see how things were done. It gave me a good insight and I picked up quite a bit". "I watched two days' worth of video's on topics such as COSHH, First Aid, Safeguarding, Moving and Handling. I was then placed with a supervisor to shadow and wasn't allowed to do anything on my own until I knew all of the people who live her and their needs." "During the induction I covered; food hygiene, COSHH, moving and handling and safeguarding. We were assigned a mentor at the beginning to meet weekly to discuss things."

We looked at the training and support staff received to help them undertake their roles effectively. We were told training involved watching dvd's and staff competency was assessed through workbooks. We were told staff were expected to complete training in their own time. We also received information from the local authority that the home did not take advantage of training they had available. We found the training policy and provider commitment to support three days paid training had not been disseminated to the staff team which had impacted on staff taking up training opportunities. The registered manager said this was because they had been unaware of this in the policy and were under the impression that staff had to attend training in their own time.

We saw staff had completed training in areas such as Fire Safety, Safeguarding, Moving and Handling, Health and Safety, Infection Control, COSHH, Food Hygiene, Medication, Mental Capacity and Equality and Diversity. The training matrix captured when training had been undertaken and when updates were required. Staff told us they had enough training available and said they felt well supported. Staff told us; "We get plenty of training. We are kept up to date. I feel well supported". "I've been provided with all relevant training here. They are really helpful. The manager has been brilliant and really looks out for us". "There has been training that I would like to do but it's difficult when you are trying to do it in your own time."

Staff told us they received regular supervision as part of their ongoing development. Supervision provided the opportunity for staff to discuss their work with their manager, in a confidential setting. We looked at supervision records and saw they were able to discuss their work, training opportunities and any concerns. One member of staff said; "They are usually every three to six months, but they are consistent". Another member of staff said; "I find them to be useful sessions where we can discuss our work".

We asked people for their views on the food and received positive comments regarding the quality of the food and choice available. A staff member told us; "Good variety of food and freshly prepared on the day."

We saw that the dining area in the lower ground floor lounge was appropriate to people's needs, During

meals, the table was set with napkins, and cutlery and we saw drinks were available. Staff were clearly aware of their roles and ensured everyone was served in a timely manner. We observed people being asked what they would like to eat, with alternatives being suggested if they did not like what was available. One person said they did not want to eat anything as they were not feeling hungry and the staff member offered to make them a sandwich. We saw people were given the choice as to where they wished to eat. We saw some people remain in the lounge to eat, whilst others had both breakfast and lunch in their bedrooms.

We looked at how the service ensured people had sufficient amounts to eat and drink. We saw people had appropriate nutritional and risk assessments in place. The home also had a nutritional file in place which detailed people's nutritional or fluid issues, including who needed thickened fluids and if so at what consistency. We also saw that people were weighed on either a weekly or monthly basis dependent on nutritional risk or their scores on the MUST tool. We saw that fluid charts were in place within each person's care file. This was updated throughout the day and contained the overall daily recommended fluid intake along with a running tally of what each person had drank along with records of any output. A person who used the service told us; "They have been really helpful. I am eating much better now and I am putting weight on." A relative told us;[Person] likes the food and doesn't seem to be losing weight" Staff told us; "We attempt to make pureed food look more appetising." "People are given milkshakes and fortified drinks during the day as we need to keep people's weight up."

We saw that the home was responsive when they had concerns about people's nutritional needs. One person had been referred to SALT (Speech and Language Therapy) due to concerns about their difficulty in swallowing and was subsequently placed on a pureed diet. We saw this was provided during the inspection. We also saw that another person was reviewed regularly by SALT and during their last visit had recommended that the person be Nil by Mouth, and just fed via PEG. The staff had amended the care plan and made sure the person was aware of the changes and why these had been introduced.

Staff were able to tell us people's individual needs and requirements. We saw involvement from a variety of different professionals recorded in people's care plans which included; mental health teams, physiotherapists, falls team, district nurses, opticians, later life and memory nurses, tissue viability nurses and GP's. People were encouraged to maintain their registration with their own GP and the home liaised with nine different GP's on behalf of the people living there.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager maintained a DoLS matrix which identified when an application had been made, granted and expired. We saw MCA/DoLS information was stored in people's care plans, including when an authorisation had been submitted. Staff were able to tell us who was living at the home with a granted authorisation and what the safeguards entailed. We asked staff about the Mental Capacity Act to ascertain their understanding. Staff told us; "I have done training on the Mental Capacity Act and know about DoLS

(Deprivation of Liberty Safeguards)." "I've attended training. It relates to restrictions on people. For example, we always make sure people have their walking aids and that people can get up when seated at the table. We consider what obstacles are in people's path and bed rails are only used for safety and if deemed safe to do so." We saw evidence of best interest meetings being conducted and people's power of attorney was identified in care plans.

We looked in peoples care files and saw people had signed consent forms to receive care and treatment. We also observed during the inspection, staff seeking people's consent prior to undertaking care and support. People were asked what they would like for meals, if they would like to take their medication and if they wished to take part in activities. People who required support to transfer or with walking, were asked for their consent before staff commenced any procedures and explained what they were going to do. People confirmed staff sought consent before supporting them, one person told us; "Staff ask for my consent, within reason I can do what I like."

We saw people's bedroom doors displayed plaques with people's pictures or pictures of interest and meaning to the person. There were also boards displayed informing people living at the home of the date, season and current weather. However, we saw limited evidence of dementia friendly resources or adaptations in any of the communal lounges, dining room or bedrooms. This resulted in lost opportunities to stimulate people as well as aiding individuals to orientate themselves within the building.

We recommend that the service explores the relevant guidance on how to make environments used by people living with a diagnosis of dementia more 'dementia friendly'.

Good

Is the service caring?

Our findings

The people we spoke with were positive about the care provided. People living at the home told us; "We are all well looked after here. We are kept warm and clean. Overall they are providing good care as I couldn't cope at home anymore." "It's very good. If you ask for something, it usually appears very quickly." "I would say it is smashing here." "It's very good here, they really look after you."

People's relatives and visitors we spoke with were also complimentary about the care provided. Relative comments included; "They are very good and very pleasant. They look after [person] very well. They seem clean, well-groomed and well cared for. Another relative said; "I think its excellent. As a family we are very happy and are satisfied. The care is good and the staff are all lovely. I think we are lucky our relative has been able to come here. Our relative is always presented well when we visit". "I think it's brilliant here. The staff are really helpful." "We've no concerns about the care being provided, second day here [person] smiled for the first time in ages, we're very happy with everything."

The people we spoke with told us they liked the staff that cared for them and they were treated with kindness. People said; "On the whole the staff are very good. Most of them seem very kind." "The staff are very kind and very caring, they really are." "The staff are very well mannered and always ask me if I am ok and if there is anything I need." "Staff are always pleasant and polite. They ask me if I'm okay as they pass my room."

During the inspection we spent time observing the care provided throughout the home. We observed one person, who was bed bound, calling out for assistance every 10 to 15 minutes. Staff responded timely to see if they needed anything and provided reassurance. We observed staff members being attentive to people's needs. On one occasion a carer noticed a person was sat uncomfortably and after speaking to them they went to another lounge to get the person an extra cushion. We observed a person encountering difficulty blowing their nose and the staff quickly responded to offer support.

We looked to see how the home respected people's rights and maintained people's privacy and dignity. We saw information displayed on the notice board identifying two staff members working at the home who were dignity champions. A dignity champion is a designated person who is passionate about maintaining people's human rights and support the team to achieve this. People told us they felt the staff treated them with dignity and respect. People using the service told us; "The staff treat us all very well." "Yes definitely. They always knock on my door, even when it is open." "I've been brought up with dignity and respect myself and I get treated with that here."

We saw staff treating people with dignity and respect. We saw staff were discreet when asking people if they needed support to use the toilet. Staff told us; "If we are providing care in people's rooms, I will close the curtains and respect people's choices." "If people don't want me to wait in the toilet with them, I will step outside to give them privacy." Relatives told us; "It's very good here, I'm happy with the care being given, [person] is always treated with dignity and respect." "The staff are all very good, very good and treat [person] with respect."

People told us staff promoted their independence where possible. We saw staff promoted people's independence during mealtimes. Staff ensured that they went at the person's speed and asked if they were ready for the next mouthful before providing this. We also noted that staff tended not to engage people in conversation when supporting with eating, sitting quietly and only speaking to ask if they wanted the next mouthful or a drink.

We observed staff asking one person who looked troubled during meal time if they were okay. The person told them they were just tired. The staff member encouraged them to finish their meal and provided assistance, before suggesting they rest in their room for a while and reassured them that they would check on them regularly.

People using the service told us; "They encourage me to eat myself, but help if you need it." "They let me do bits and pieces myself. They really are very good." Staff said; "Even if people can't eat and drink, I'll place cutlery in their hand and assist them to have a go. One person hasn't stood up for quite a while because of poor mobility, but we continue to try with them by using the stand aid."
A relative told us; "They had [person] standing the other day, first time they have done that in a long while. I will be ringing [person's] sister later to say how well they are being looked after."

We saw staff had attended end of life training and the home was equipped to support people nearing the end of life. We saw in the foyer of the home a memorial table that was a celebration of people's life. The table contained memorial cards and there was a book on the table for people and relatives to express their gratitude to the care provided and to share their memories.

A staff member told us; "I feel very privileged. I'm honoured to be in people's home. People living here, their relatives and friends take you in to their lives. It's a lovely home." "Care here is amazing. I wouldn't hesitate at having my whole family live here."

Good

Is the service responsive?

Our findings

The people we spoke with told us they felt the service was responsive to their needs. People who used the service told us; "I feel like I get everything I need here. All I have to do is ask if there is anything I would like to change." "I've been here for four weeks and its smashing and I'm getting everything I expected." "We receive baths and showers regularly and our clothes are washed and ironed."

We saw that each care plan contained a checklist which indicated that each person had been asked a number of questions upon admission, including whether they wanted to be involved in their care plan and whether they wanted their family to be involved. We saw evidence that discussion with families about care plans had taken place as these had been documented on the communication sheet in each person's care plan.

We asked people if they had been involved in developing their care plan. People using the service told us; "I get to stay in bed, which is what I want and asked for. I enjoy puzzles and playing dominoes, which they help me to do." Relatives told us they felt they were informed about people's care. Relative comments included; "I have seen the care plan, they asked for our opinions," They do speak to me about it, but not very often, however we have just discussed implementing a pureed diet for my mum, this is following medical advice." "I have seen the care plan and they ask me to sign it when I do."

We saw care files captured information about people's life histories and covered family life, working life, things people enjoyed, important people and dates, likes and dislikes. We saw that individual care plans had been included which highlighted any problems or needs, the desired outcome of the person and action points to achieve this.

We found clear guidance in a person's care file regarding the support provided to a person who became agitated during personal care tasks. A 'watchful waiting clinical care plan' had been introduced for a set period of time. This process is used to optimise treatment and care for people with behavioural and psychological symptoms of dementia. This involved staff documenting the entire process in detail along with the person's reactions, in order to formulate an action plan of how best to support the person.

We found daily checks were undertaken regarding people's needs and charts recorded when personal care tasks had been supported. For example; oral hygiene, pressure care, fluids and nutrition. We checked five files and noted that overall these had been completed consistently. We cross referenced three people's requests regarding bathing preferences against their bath/shower chart and observed their preferences were met.

The home had a rolling programme of activities. We spoke to the activities coordinator who told us they arranged two group activities and two 1:1 activities with each person per week. The coordinator spoke to people to ascertain their requests for 1:1activities; these included playing dominoes, puzzles, listening to music or just having a chat.

The coordinator also stated they provided dementia friendly activities, including sensory activities which focused on touch, feel and smell including aromatherapy. They also used a memory ball to facilitate reminiscence sessions.

We saw scheduled activities had involved a team visiting the home that brought old style equipment and the care coordinator scheduled sing songs to jog people's memories and provide people with a connection. The land army girls who wore old war uniforms, and sang war songs had recently visited.

Entertainers were scheduled monthly and the home invited people's families to attend and laid on a buffet. There were no prescriptive visiting times and families were welcomed to bring their family pets in to the home. We were told of five dogs that regularly visited people living at the home.

The activities coordinator had developed an activities file, which contained a section for each person living at the home and detailed their likes, dislikes and a description of the activities they had participated in.

We looked at how complaints were handled and responded to. We saw an overall summary was provided of what the complaint had been and any relevant actions that had been taken. We asked people who lived at the home if they had ever made a complaint. People told us; "I have never had to complain, but I think they would listen to me if I did, it's pretty good here." "I have never made one but I would speak to the nurse in charge and I'm sure it would be handled properly." "I would speak to the manager and they would sort it." A relative told us they had complained about [person's] missing razor but indicated that it was quickly resolved and the razor was found.

We saw the home had received a number of compliments from people's friends and relatives. Compliments included; 'Just to say thank you for everything and making my relative as comfortable as possible during their stay.' 'Thank you for so much kind and thoughtful care.'
'Thank you for doing such a wonderful job of looking after my mum and dad.' 'To all the staff. Thank you for your care.'

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager and deputy manager were available throughout the inspection.

On arrival at the home we asked for a variety of documents to be made accessible to us during our inspection. These were provided promptly. We found all records we looked at to be well maintained and organised which made information easy to find. However, we had to raise a concern with the registered manager about the storage of confidential information. On arrival at the home, we noted that care files containing people's plans and care records were on the corridor outside people's bedrooms. Daily care accessible to others contained; fluid intake, output, skin integrity, behaviour/mood information. We also saw a file containing personal care information left in dining the room. The registered manager expressed being unsure why this had occurred and indicated that care files were kept in people's bedrooms or locked at the nursing station when people were in communal areas so that fluid intake charts could be completed at the time people had a drink to maintain a contemporaneous record.

This was in breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance because the provider could not demonstrate they were maintaining records securely.

The registered manager was visible throughout the inspection people and their relatives spoke highly of the home and the management team. A person and their relative told us; "We would definitely recommend this home to other people. The management are brilliant. They are not just here during the day but I've seen them when I have visited late in the evening too." Other comments from relatives included; "I'm aware of who the manager is, she is very approachable." "I've spoken to the manager many times, I also see her on the shop floor helping out."

Staff described an open and transparent culture promoted by the registered manager. Staff comments included; "The manager is always there for us. If we need anything she is always there. She is good." "The manager has been very supportive of me. She looks after her staff." "It's well managed. The manager really does seem to care about the staff and the residents who live here." "The manager is approachable and visible in the home. A firm but fare manager." "We work really hard but it's a lovely atmosphere and home." "We are a good team and the registered manager is supportive."

Team meetings were conducted regularly. We looked at the minutes from the most recent staff meeting which had taken place in May 2016. We saw a range of topics were discussed including safeguarding, incidents/accident reporting, MCA/DoLS, infection control, training, communication, medication and activities. There was an 'any other business' section where staff were able to voice their opinion. One member of staff said; "We feel listened too in the meetings and are able to contribute."

We saw the registered manager sought feedback from people using the service and their relatives. There were relative meetings every three to six months which were publicised on the notice board in the entrance to the home. There was also a suggestions box and comments book in the home entrance which was emptied fortnightly if relatives or visitors wanted to make an anonymous suggestion in between meetings. This was emptied and read fortnightly and suggestions captured and actioned.

We looked at the minutes from the most recent residents meeting. The last recorded meeting was February 2016. We saw topics for discussion included issues/concerns, if people were happy with the care, food, cleanliness, upcoming events at the home and the new car park it the home. The meeting was summarised saying it was a positive discussion with no complaints or issues being raised.

We looked at the systems in place to monitor the quality of service provided. We saw audits were undertaken of care plans, safeguarding, medication, infection control, admissions processes, complaints/concerns, accidents/incidents and staff recruitment processes. We saw that where any discrepancies were identified, there were records of what action would be taken. However, we found the provider does not currently do an audit but the registered manager explained that a new area manager had commenced in post with the view to rolling this out across the homes. We saw the manager conducted a bi-monthly health and safety audit to ensure the premises were safe for the people living there. This covered areas such as fire doors, slips, trips, falls, legionella, PAAT testing, the kitchen area, laundry, bathroom areas and hazardous substances. There were also regular checks of window restrictors, to ensure they were in good working order.

We saw that the home had a policy and procedures file in place. This included key policies on medicines, safeguarding, MCA, DoLS, moving and handling and dementia care. The policies contained within the file were from 2008. Following the inspection, the registered manager informed us that updated policies were kept separately with the specific topic area and sent us the safeguarding policy to confirm this. The registered manager acknowledged that the system had been confusing and had devised a link to signpost the reader from the basic policy to the updated version kept with each topic specific area.

Providers are required by law to notify CQC of certain events in the service such as serious injuries, deaths and deprivation of liberty safeguard applications. Records we looked at confirmed that CQC had received all the required notifications in a timely way from the service.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found that the provider was not doing all that is reasonably practicable to mitigate risks. Regulation 12 (2) (b) We found that the provider had not protected people against the risk of associated with the safe management of medication. Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance We found the provider had not maintained records securely. Regulation 17 (2)(c)