Crown Care I LLP

Balmoral Court 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?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 1 and 2 December 2015 and was unannounced. This means the provider did not know we were coming. We last inspected Balmoral Court Care Home in January 2014. At that inspection we found the service was meeting the legal requirements in force at the time.

Balmoral Court Care Home provides nursing and personal care for up to 62 older people with dementia related conditions and other mental illnesses. At the time of our inspection there were 42 people living at the home.

A new manager had applied to become the registered manager for the home. 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.

Summary of findings

We found that parts of the home were not well maintained. All reasonable steps had not been taken to reduce risks and make sure that people's care was provided in a safe and hygienic environment.

New staff were suitably recruited and there were enough staff to safely meet people's needs. Systems were in place for protecting people against the risk of abuse and responding to any allegations of harm or abuse.

The home provided a service to people who often had complex mental health needs. The principles of the Mental Capacity Act 2005 had not been consistently applied where people lacked capacity to make important decisions about their care and treatment.

People were supported to receive health care services and maintain their health and well-being. The arrangements for managing medicines did not fully protect people living at the home.

Nutritional needs were assessed and care planned, though food intake was not always properly monitored. We found concerns about the limits on snacks and drinks, support with eating and drinking, and people's experiences at mealtimes.

Staff were given training relevant to the needs of the people they cared for and told us they felt supported in their roles. Individual supervision and appraisal was not being routinely provided for all staff to support them in their roles and assist with their personal development.

We observed many caring interactions between staff and people living at the home. However, there were times when people's requests and dignity were not respected.

People had care plans for meeting their needs and staff knew individuals well and how they preferred their care to be given. Care was adjusted in response to changes in people's needs.

A range of activities were offered to help people meet their social needs and be involved in their local community. We have made a recommendation about developing a more dementia-friendly environment.

People and their relatives were generally happy with the care provided. Any complaints about the service had been appropriately responded to and investigated.

A new manager was in post who was providing leadership to the staff team. The manager and provider were keen to promote an inclusive culture. Checks and audits of standards at the home were carried out. However, these had not been fully effective in making improvements to the quality of the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment, the premises, consent, nutrition, dignity and respect, and the governance of the service. You can see what action we told the provider to take at the back of the full version of this report.

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. The environment was not fully safe, clean and free from hazards and odours.

Robust arrangements were not in place to ensure people always received their medicines safely.

Steps had been taken to protect people from abuse and respond appropriately to any safeguarding concerns.

New staff were properly checked and vetted and there were enough staff to meet people's needs.

Is the service effective?

Requires improvement

The service was not consistently effective. Formal processes under mental capacity law had not always being followed to protect people's rights.

There was a lack of a structured system to ensure that staff were given regular supervision and appraisal.

The availability of snacks and drinks, support at mealtimes and monitoring of nutrition required improvement.

Staff were provided with suitable training to meet the needs of the people they cared for.

People were given appropriate support to access health care services and maintain their health and well-being.

Is the service caring?

Requires improvement

The service was not consistently caring. Although staff were caring in their approach, people's expressed preferences and dignity were not respected at all times.

People were able to make some day-to-day decisions about their care.

The staff knew the support needs of people well.

Is the service responsive?

Good

The service was responsive.

Activities were provided for social stimulation and there were opportunities for people to access the local community.

People had care plans for meeting their assessed needs which were adapted as their needs changed.

Action was taken to respond to and resolve any complaints about the service.

Summary of findings

Is the service well-led?

The service was not consistently well-led.

An experienced manager was in post who had applied to become registered.

Some systems were in place or were being arranged to take account of the views of people using the service, their representatives, and staff.

Quality assurance processes had not been fully effective in identifying and acting on where improvements were required.

Requires improvement

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

The inspection took place on 1 and 2 December and was unannounced. The inspection team consisted of an adult social care inspector, a specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the home prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also contacted the local authority that commissions the service. They told us they had last visited the home in August 2015 at which time most of the actions for improvement they had set had been completed.

During the inspection we talked with 16 people living at the home and eight relatives or visitors. We spoke with the managing director, the manager, the deputy manager, and with 18 nursing, care and ancillary staff. We observed how staff interacted with and supported people, including during a mealtime. We looked at nine people's care records, medicine records, staff recruitment and training records and a range of other records related to the management of the service.

Requires improvement

Is the service safe?

Our findings

People and their relatives expressed no concerns about safety at the home or how people were treated. One relative commented, "We've never seen anything untoward."

At the time of our inspection there was a problem with heating on the ground floor and it was noticeably cold in this area. A relative told us the underfloor heating was not working in their family member's room. They said, "I've had to tape the window in (relative)'s room to stop the draughts, the curtains were blowing and the window was shut. I put a warm blanket down the back of (their) chair to stop them being chilled, that's why the bedroom door is open, so the corridor heat keeps the room warm." The manager arranged for a temporary heater to be put in place and assured us the heating problem was being followed up.

One of the lifts was out of order and a stairwell was unusable following a water leak and this was causing some concern for staff and visitors. The lift had been reported for repair and all stairwells and the lifts were key coded to help keep people safe within the building.

There was a marked contrast between the two floors of the home. The ground floor had new carpets, though we noted the cream carpet in the lounge was soiled. The upper floor appeared quite bare and there was a noticeable odour in the corridor. Housekeeping staff were visibly working throughout the day and were mindful of keeping potentially harmful cleaning chemicals safe and locked away when not in use. They showed us they worked to schedules to prioritise areas of the home for cleaning and they used products designed to eliminate odours from incontinence. These methods had not been successful and further efforts were needed to get to the root cause of the problem.

We observed a continence accident during a meal time resulted in a trail of urine on a chair and across the dining room floor on the ground floor. This was pointed out to staff because it seemed to go unnoticed. The floor was mopped but remained wet and no sign was put in place to remind people that the floor was still wet. No attention was given to the chair and it remained contaminated and uncleaned.

We were shown that a monthly safety inspection was carried out by the home's maintenance person. This covered a range of checks including fire safety, electrical items, floor coverings, lighting, hot water temperatures, and emergency exit routes. However, we observed some issues of poor maintenance in the home. In the upstairs dining area the sink unit drawer front was broken off and exposed the inner drawer, the hand towel dispenser front was missing and the towels piled loosely in it. A number of handles to the windows in the dining room and in one of the lounges were broken or missing. The latest safety inspection did not address these issues, though comments were noted about the need to replace a number of windows, mainly those with wooden frames. Chain window restrictors were in place on the upper floor to prevent accidental egress. The manager provided us with the windows risk assessment they had carried out that had determined the risk as low and identified the control measures in place. We concluded that the provider had not ensured that all parts of the premises were clean and properly maintained.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed a number of people in the lounge seated in wheelchairs in the downstairs lounge in the morning. Some were seated with no foot rests, some had no socks or stockings, and all had no shoes or slippers. We saw some people had been moved later into lounge chairs, though three people remained in wheelchairs, one with no footrests and the others without shoes or slippers. There were no lap straps used. This gave us cause for concern that people could be at risk of falling or hurting themselves. Where footplates were not used it was recorded in the person's care plan. However some footplates were stored in bedrooms and could cause a trip hazard and injury if fallen on. We concluded that the provider had not done all that was reasonably practicable to mitigate risks to people using the service.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were ordered on a monthly basis and stored in a secure treatment room and two lockable medicines trollies. All medicines were administered by the nursing

Requires improvement

Is the service safe?

staff who were trained and had their competency to handle medicines assessed. On occasions, senior carers who were trained in safe handling of medicines supported agency nurses with administration.

There was a large treatment room, with the required cupboards and storage, however the room was cluttered and disorganised and the floor was sticky. We observed an agency nurse had difficulty locating a pain relief medicine for a person and the regular nurse had to contact the GP practice to obtain a further supply. The person was complaining of pain and the agency nurse, through no fault of their own, was unable to meet the person's needs in a timely way.

People's needs in relation to their prescribed medicines were assessed and care planned. Each person had an identification sheet at the front of their medicine administration records (MARs). This specified their preferred method of taking medicines, such as 'On a spoon with a drink of water or milk'. We examined a sample of MARs and found gaps where two people's medicines had not been signed for that morning and for the application of a transdermal patch for another person the previous day. We queried these deficits with the nurse and deputy manager who told us they had forgotten to sign the MARs, and, in one instance, omitted to enter the code to state the reason why medicines were not given. These instances showed us that the provider's medicines policy and procedure, to administer medicines and then confirm by completing the records, was not always being followed correctly. We concluded that the provider had not ensured that medicines were managed safely.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We viewed people's risk management records which were held electronically. Each area of the needs assessment prompted staff to assess any associated risks. Suitable measures to minimise risks including mobility, falls, nutrition and mental health were recorded. Risks were also summarised in the overall summary of each person's care needs to guide staff on how to keep the person safe from harm.

Accidents and incidents were reported and details were fed electronically into staff handovers. The reports were sent to the manager to check and follow up on any safety issues and a monthly analysis was carried out to identify and act on any trends identified.

Staff received moving and handling training but not always before they began working at the home. Where this was the case, the manager told us they were not allowed to assist in any moving and handling activities until they had completed training. Staff reported that they had sufficient equipment for safe moving and handling, including slings, slide sheets, handling belts and airflow cushions and mattresses. There was one hoist in use and a second was being repaired.

New staff were properly checked and vetted before they were employed. We saw appropriate recruitment information was obtained including application forms, references from previous employers and checks with the Disclosure and Barring Service. Checks of qualified nurses' registration to practice were conducted and the managing director told us these were monitored monthly to ensure they had not expired or lapsed.

Staffing was determined on a monthly basis according to the numbers and dependency of people living at the home. The staffing model used took account of the needs and levels of supervision that people living with dementia required. The current staff numbers were two nurses and eight care staff during the day and one nurse and four care staff at night. During the day the numbers included senior carers with roles of co-ordinating people's care delivery and supporting the care staff. All of the manager's hours and a proportion of the deputy manager's hours were in addition to the staffing levels. The manager and deputy manager operated an on-call system outside of office hours which enabled staff to get advice and support and, where necessary, to escalate emergencies.

The manager told us there was one vacancy for a qualified nurse that was being advertised and a new nurse had just been appointed and was undergoing induction. They confirmed the home was regularly using agency nurses to meet the staffing levels, but felt this was improving. The rosters for nursing staff were difficult to decipher though it appeared that a number of different agency nurses were currently being used. The manager told us they would look into this to ensure the same nurses were requested for continuity, wherever possible.

Requires improvement

Is the service safe?

We observed there were enough staff on both floors of the home to meet people's needs. The staff were visible, worked at a steady pace and took time to talk to people as they went about their work. Daily allocation sheets were completed that showed how staff were deployed, including allocating staff to supervise people in the communal areas.

We saw people were informed about their rights to be protected from abuse and neglect in the guide to the service. Staff had access to the provider's safeguarding and whistle-blowing procedures and were given training in how to recognise and report abuse. The staff we talked with understood their roles in protecting people from being harmed. The managing director told us a 'safeguarding toolkit' was going to be used in supervisions to further check staff's knowledge and understanding of the safeguarding process. A policy had been introduced on the 'duty of candour'. This duty requires registered people to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong.

In the past year there had been five safeguarding alerts raised about the service. The management had co-operated with investigations and taken appropriate steps to change practices, where necessary, and prevent incidents from re-occurring. For example, in response to the latest alert, a range of actions had been taken to ensure the home's resuscitation policy was reinforced and followed.

We checked the systems for managing people's personal finances. Where people had their money held for safekeeping, records of transactions were kept which were signed and countersigned by a witness. However, some entries did not explicitly state the reason for money being paid out and corresponding receipts could not always be readily located. One person made regular withdrawals but had not been asked to sign the records to confirm they had received their money. The manager acknowledged that these matters had not been highlighted in the recent financial audits and told us more thorough checks would be carried out in future.

Requires improvement

Is the service effective?

Our findings

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).

The majority of staff had received training in the MCA and DoLS and relevant policies and procedures were available for guidance. We found that although the nursing staff were qualified mental health nurses, they had not consistently applied the principles of working within the MCA. Mental capacity assessments were not always carried out to establish people's capacity to make important decisions about their care and treatment. This included decisions around bed rails to be put in place for safety and for medicines administration. For example, where a person consistently refused their medicines and for another person whose medicines had been given covertly (disguised in food or drinks).

The deputy manager took a lead role in making DoLS applications for people living at the home. At the time of the inspection DoLS had been authorised for nine people and applications made for a further seven people. However, the manager recognised these numbers were low given that most of the people living at the home had complex needs requiring nursing care, including dementia-related and other mental health conditions. They told us further DoLS applications would be prioritised. Where DoLS had been authorised, we found there was a lack of care planning in relation to the safeguards to demonstrate how people's rights were being protected. There was also no system for checking when DoLS were due to expire, though this was implemented by the managing director during the inspection.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessments were carried out into people's nutritional needs and risks, and weights were monitored. Nutrition care plans were recorded which specified the person's dietary requirements and, where applicable, any prescribed supplements and support with eating and drinking. However, food and fluid charts were not consistently completed. For example, no records had been made of food and drinks since lunch time the previous day for a person with specific dietary needs following surgery. Their records also showed no evidence of any snacks being offered or taken between meals. A staff member told us the person was regularly refusing food, however this was not indicated in the records.

At lunch time we observed that staff were very busy and on occasions people were not effectively supported. On the ground floor the dining room was very cramped when everyone was seated, as many people needed staff to sit with them whilst eating. At the beginning of lunch a staff member was washing plastic beakers for drinks and the tables had not been set. The tables had two table cloths but no placemats, serviettes, cutlery, or condiments.

Although all staff helped at the meal time the ambience was disorganised resulting in a poor experience for some people. One person was pouring their soup and tea together and it was some while before this was realised and rectified. Whilst most staff sat with people assisting them with their meals, one staff member stood over a person trying to persuade them to eat. Bread was placed nearly out of reach and we saw one person struggled to reach it. The soup could easily have been overturned and it was some minutes before this was recognised by staff in the vicinity. There was no specialist dementia crockery used to help people with identifying their food and eating independently. Where people had their meals in their bedrooms, they were delivered without trays, food covers, condiments or serviettes.

Staff were mindful of supporting people with nutritional risks. Care staff on the upper floor told us, "We encourage people to come and sit in the dining room when they want, it's best just to go at their pace. Anyone who is at risk of choking, we try to have them in here (the dining room) and, if not, a member of staff has to stay with them", and, "We need to prompt a lot of residents to eat. We have two

residents that require feeding, with pureed meals and thickened drinks and there are others on thickened drinks." We saw a staff member ensured that a person's food had sufficiently cooled before helping them with their meal.

We talked with the catering staff who told us they thought there could be better communication with them about people's weights and where nutritional supplements were prescribed. They said on occasions soft meals were returned to the kitchen but they were not told the reasons for this. They described restrictions on purchases set by the previous manager and felt constrained in what they were able to order and provide. For instance, they said the budget did not allow for additional expenses at Christmas and for providing extra snacks between meals.

There were no jugs of water in the communal areas or in people's bedrooms and domestic staff told us this was usual practice in the home. We observed that tea, coffee, juice and biscuits were served in the morning and afternoon. A relative commented, "There is only a tea trolley because you (the inspection team) are here. They do individual drinks for the vocal people and the people walking all the time, the quiet one's get missed." Care staff told us they always served drinks to everyone though the only snacks provided were biscuits and bananas for people with diabetes. They said fresh fruit was rarely sent up from the kitchen and one staff member said at times they brought in extra snacks for people. We brought these matters and our observations from the mealtime to the attention of the managing director and manager who told us they would urgently review the situation.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us there was a delegated system for providing all staff with individual and group supervisions. Those staff who took responsibility for giving supervision had different views on how often sessions were meant to be provided. The manager clarified that the frequency was set by the local authority that commissioned the service and was six supervisions annually, which could include two group sessions. There were no schedules drawn up to forward plan when supervisions would be carried out and the managing director told us a report of those undertaken could not be relied upon to be accurate. A check of four staff files showed that the provision of supervisions and appraisals was variable, with only one of the staff members being on course to meet the required frequency for the year. This meant there was no structured system to ensure that all staff were supervised and supported in their professional development.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff undertook induction training that was based on the Care Certificate. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. The staff on duty included a new care assistant and a new qualified nurse, both of whom were undergoing their induction. They told us day one had included orientation to the building and introduction to safe working practices especially fire procedures, emergency equipment and, for the nurse, handling medicines. We observed senior carers gave advice and support and a new staff member reported that their mentor had been invaluable in the first few days of their employment.

The manager provided us with a matrix that gave an overview of the training completed by the staff team. This showed that most staff had completed training in safe working practices within the last year. A range of other courses had been undertaken including understanding dementia, mental health awareness, managing conflict, nutrition, and end of life care. The majority of training provided was through e-learning and there was practical face to face training for topics such as moving and handling, fire safety and first aid.

Staff were encouraged to be involved in training and told us they were confident in their roles. Some care staff felt they would benefit from more training in caring for people living with dementia and managing challenging behaviour. The manager confirmed that further training in these areas had been booked. The staff we talked with felt that the nurses and senior carers were supportive. One staff member commented, "We have a good team of care staff." A senior carer told us, "I'm doing a diploma in management and leadership. I get most of my support from the deputy manager."

Most of the relatives we talked with felt their family members were cared for effectively. Their comments included, "We are very satisfied with it all. I come every day to see (relative). We get told about everything, no problem.

Requires improvement

Is the service effective?

I'm very happy with (relative's) care"; "I came in last week and (my relative) had a bandage on their foot. Staff said it was a pressure sore, but they had them straight on a special mattress and the nurse in, so they had done everything"; and, "My (relative) went downhill a while ago, and wouldn't eat, but they were on to it and got them on a food chart, and prompted them till they put on weight. We thought we were going to lose our relative for a while but they are so much better now."

People's medical history had been obtained and their physical and mental health needs were assessed. People accessed a range of health care services. Visits and appointments with health care professionals were documented with details of any advice, treatment and changes to medicines.

Requires improvement

Is the service caring?

Our findings

We observed an incident that could have been managed in a more caring and considerate way. A lady needed to get changed following a continence accident and made it clear she did not want assistance from a male care assistant. Instead of asking a female colleague to take over, a male care assistant persisted in trying to persuade her. They then passed clean clothing to the lady in the toilet and some time later we saw she had managed to change herself. None of the staff checked on her to see if her personal hygiene had been attended to and her wet clothes were left on the toilet floor.

At mealtimes we saw that people were not always involved in deciding what they were given to eat. There was no menu written up for people to see, even though there was a large blackboard on the wall. At lunch staff offered some people the choices of alternative meals, though they did not always show them the options. Other people were just presented with a plate of food with a typical statement of, "There's a nice meal for you." On a number of occasions people expressed requests which were disregarded. Dessert was rice pudding and when a person asked for ice cream they were told, "Oh, you had ice cream on Sunday, you always have ice cream on a Sunday." A person asked for cranberry juice, but was told, "Sorry, there's none left, we have orange." Another staff member said, "No, there's not, I used the last of the juice - there will be some downstairs in the kitchen", but none was fetched.

Another person caused great debate because they asked for a bacon sandwich; whilst the manager thought this was possible and discussion took place, the person's request was not facilitated. We heard one care assistant say, "(Person) always asks for a bacon sandwich", and then carry on with what they were doing. During meals some people were given 'dignity aprons' to prevent food spillage on their clothing and protect their dignity. No serviettes were available and we did not see any wiping of hands, face or clothes until a new care assistant said to the person they had been assisting, "We'll just wipe your hands now." Our observations led us to conclude that people were not always treated with dignity and respect.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Those people who were able to express their views said they were happy with their care and the staff who cared for them. One person told us, "It's good here." Another person said, "I've been in other homes and this is better." A third commented, "The lasses (staff) are nice." People we talked with appeared very relaxed and happy to engage. One pointed out a member of staff and said, "She's lovely." This person said, "I get everything that I want." It was evident by their non-verbal cues that people had confidence in the staff who were assisting them.

Relatives' comments were generally positive about the care. One relative said, "We are very happy with it all, my (relative) has been here five years and we are happy with it, they look after them very well." A second relative told us, "They let us know about everything, we are in four times a week, so we see everything." A third said, "We are happy with it all, it gives you confidence."

Other comments from relatives included, "We are happy with the care, our relative has been here four years"; and, "No problems, (relative) has improved since being in here." We saw visiting relatives making themselves a drink in the dining room kitchen area. Relatives told us they could visit whenever they wanted.

People and their relatives were given a guide to the service that explained what they could expect from living at the home. A range of information was also displayed, such as forthcoming events, though most of this was in the front entrance to the home and not accessible to everyone. The manager told us they were reinstating 'resident and relative' meetings to get people's feedback and suggestions on the running of the home.

The staff we talked with told us they enjoyed working at the home and felt they had very good relationships with the people they supported. Staff had a clear understanding of people's needs and desires and tried very hard to facilitate these wishes. As an example, one person decided they wished to celebrate their birthday the following day and a member of staff was calling at the shops on their way home to buy the necessary items for a party.

We observed staff interacting with people in a very caring way, asking them if they could be helped, taking time to listen to what they were saying and engaging in conversations that were meaningful. We saw good interactions when care staff were assisting people in

Requires improvement

Is the service caring?

wheelchairs or walking with them. Domestic staff showed good skills in diverting people who were agitated and explaining what they were doing when people were curious.

Most of the staff had undertaken training in equality and diversity to help them understand the importance of treating people as unique individuals. In care records we found varying degrees of life story work had been completed. Staff told us that due to people's complex needs they often relied on relatives for background information and to advocate on people's behalf during care planning. There were some very good examples of care summaries which gave a real sense of the person and the ways they preferred to be supported.

People were generally clean, although not always dressed in a co-ordinated way and one person was wearing a torn jumper. Many people were without shoes or slippers. Staff said, "We just can't get them to keep them on." Some people were resistant to intervention from staff and looked dishevelled. For instance, staff had not been able to persuade some of the gentlemen to shave or change marked clothing. The staff were concerned because even though they had tried everything they knew it still appeared as if people were uncared for. The staff had a good understanding of the importance of respectful and dignified care and the positive effects that it had for people. Some staff felt they would like more in-depth training in person centred care delivery for people living with dementia.

We found that where they were able, people could make some every day decisions. For example, it was evident people decided when they wanted to get up and those who got up later in the morning were offered choices of light breakfast. One lady told us, "I don't like getting up early", and was enjoying talking to the staff in the nurses' office and catching up on what was going on.

Good

Is the service responsive?

Our findings

The relatives we talked with told us they were kept updated by staff about their family members' welfare. One relative said, "They ring me in the morning and sometimes at night if anything is wrong, they do let me know." One relative told us they had made a complaint the previous year and visited their family member every day as they worried about them. They said the manager had dealt with their more recent concerns and told us, "I have high hopes of this manager." Another relative raised concerns with us that the managing director immediately followed up with them.

A complaints procedure was in place and five complaints had been logged in the past year. Each complaint was documented along with the action taken in response, including offering apologies and discussion with staff about improving practice issues. A compliments file was also maintained with copies of thank you cards and letters praising staff for the care people had received.

An electronic care planning system had been introduced at the home which was not yet fully embedded. Some staff were receiving further training in the system during the inspection. There was one terminal on each floor, meaning only one member of staff could access it at a time. However, portable tablets had been ordered to help overcome this problem and enable staff to update information in a timely way.

The system showed that a range of assessments were completed regarding each person's care needs, risks, and dependency levels. A comprehensive care summary was documented which provided staff with a useful overview of needs, including the extent of personal care the person required and how they communicated. The care plans we reviewed were easy to follow and gave plenty of information to guide staff on the care and support to be provided to meet the person's needs. The care plans and life story work were still being developed and we found some people's care records were more personalised than others.

Where people's needs had changed it was evident that care plans had been promptly updated to reflect this. For instance, where a person had recently returned to the home following a stay in hospital. However, we noted it was difficult to track whether referrals had been made to other professionals and if they had been involved in helping to manage identified risks. A senior carer demonstrated the way to locate and retrieve this information.

The computer system contained relevant and important information about people's individual care requirements. This included details of Deprivation of Liberty Safeguards, whether the person would wish to be resuscitated, emergency contact details and other information to assist staff in ensuring that safety was maintained. Daily reports of each person's well-being were included on the system and could be entered by any of the staff who had been trained.

All staff were given a handover at the beginning of their shifts to make them aware of people's current needs and any significant events affecting their care delivery. An agency nurse confirmed they had received a handover during which they had asked questions about any potential problems. They told us working with people with distressed or challenging behaviours was not their area of expertise and were appreciative of the support from the regular nurse and the knowledge of the senior carers on the first floor. The staff we talked with had good knowledge of the individual needs of the people they supported.

People had care plans for meeting their social needs and an account was kept of each of the activities they had taken part in. For example, one person's records we looked at showed they had participated in music, reminiscence and painting sessions, watched DVD films and had been out to local shops with staff.

The home had two part time activities co-ordinators who arranged social activities, events, and outings. We talked with one of the co-ordinators who said the care staff were good at helping out with activities for people. They told us that in addition to daily activities there was regular visiting entertainment and links had been forged with a local community centre where people attended tea dances and had lunch. Seasonal events were organised including a Christmas fayre, a pantomime and local primary school children were doing a concert.

During the inspection we observed activities being carried out including reminiscence, a Christmas film afternoon and a birthday party. One person told us, "We play dominoes, we have our bar, it's good there." Other people told us they watched television. They asked about a member of the

Good

Is the service responsive?

inspection team and the inspection and one person said, “Like Ofsted.” This then led onto a meaningful discussion between people and a care assistant that went on for some time about schools and school life.

We saw that some attempts had been made to create a dementia-friendly environment. On the upper floor there was a ‘fiddle board’ with bolts and locks on it, themed walls and touchable objects. Downstairs had some pictures but no touchable objects or themes. Both floors had a lounge designated for activities. One was set up like a music room and one as a memory room. Another room upstairs was set out in the style of a bar and was known as the ‘Balmoral Bar’. Bedrooms were well decorated with people’s belongings and photographs. Bedroom doors had the person’s name on them, though this was above eye-line and not easily seen, and there were no memory boxes or other means to help people recognise their rooms. There were not many rest places along the corridors with stimulating and interesting objects which may have increased the walking behaviours that we observed.

We recommend that the service considers current best practice to further enhance the environment in relation to the needs of people living with dementia.

Requires improvement

Is the service well-led?

Our findings

The managing director had carried out reviews of the service, most recently in October 2015. This review highlighted areas to be improved and further developed which were set out in an action plan for the manager. Audits had also been conducted to check the quality of different aspects of the service such as the environment, kitchen, housekeeping, medicines and care plans. However despite these measures the quality assurance system had not been effective in identifying and acting on most of the concerns we found during the inspection. It was also evident that the care people experienced and care practices had not been kept under close enough scrutiny to monitor and improve the quality and safety of the services people received.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager and managing director acknowledged the inspection findings and told us they were committed to improving the systems and practices at the home. The managing director said they would be devoting more time to supporting the home and strengthening the management structure. The manager noted each of the concerns we raised and included them in the home's quality assurance plan for follow up action.

The service had appointed a new manager who had been in post for just over two months. They had applied to the Care Quality Commission (CQC) to become the registered manager for the home and the adjoining care home. The intention was that the registered manager would be a general manager responsible for both of the provider's care homes which are on the same site, with a qualified nurse as unit manager in each home, and these arrangements were currently in progress.

Some staff told us there had been more than one change of manager over the past year and they had found this unsettling. They said the new manager had been well received and they were hopeful of greater stability and improvements at the home. Staff told us there was good team work and they supported one another. Their comments included, "I get plenty of support from the nurses"; "The staff are lovely and work well together"; and, "The new manager is supportive. (The managing director) is approachable and accessible. I'd feel able to discuss my work with them."

The manager was experienced and understood their responsibilities, including ensuring that CQC was notified of changes, events or incidents that occurred at the service. They told us they kept the managing director appraised of significant events through weekly reports. There was a clear management and staffing structure with 'heads of department' where staff had accountable roles for areas of the service such as catering, housekeeping and activities provision. Some staff had undertaken advanced training and had lead roles such as continence management, promoting best practice in caring for people with dementia, moving and handling, and the electronic care planning system. To date the manager had held 'heads of department' meetings and they told us they were planning a full staff meeting in the near future to get staff's views about how the home was run.

A 'resident and relative' meeting had been organised but this had been cancelled due to unforeseen circumstances and a further date was being arranged. Satisfaction surveys with stakeholders had last been carried out in May 2015. An analysis of the returned surveys showed predominantly positive results, though some people had given negative responses and comments about furnishings, the quality of the food, and the temperature being too hot in the home.

An event had recently been held with managers within the company to raise their awareness of the CQC's fundamental standards of quality and safety and regulations. The managing director told us the manager would be cascading the information to the staff team to give them an improved understanding of the standards required. Further developments planned at the home included implementing the 'dignity in care' campaign, appointing a dignity lead and continuing with the decorating and refurbishment programme. A review of the medicines system had started and more frequent medicines audits were being introduced. There were also plans to improve the way that staff training, supervision and appraisal was planned and captured by incorporating these elements into the electronic system.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not ensured that care and treatment was provided in a safe way for service users by doing all that is reasonably practicable to mitigate risks and ensuring the proper and safe management of medicines.** **Regulation 12 (1)(2)(b)(g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The provider had not ensured that all of the premises were clean and properly maintained.** **Regulation 15 (1)(a)(e)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider had not acted in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.** **Regulation 11 (1)(3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider had not ensured that staff received appropriate supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.**

This section is primarily information for the provider

Action we have told the provider to take

Regulation 18 (2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The registered person had not ensured that the nutritional needs of service users were met.** Regulation 14 (1)(4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider had not ensured that service users were treated with dignity and respect at all times.** Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider had not ensured that effective systems were operated to monitor and improve the quality and safety of the services provided.** Regulation 17 (1)(2)(a)