Pilgrims' Friend Society

Leonora Home

Inspection report

Wood lane
Chippenham
Wiltshire
SN15 3DY

Tel: 03003031445
Website: www.pilgrimsfriend.org.uk

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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

Leonora Home is one of the services provided by Pilgrims' Friend Society, a Protestant Christian organisation. It provides care and accommodation for up to 20 older people some who are living with a diagnosis of dementia. At the time of our inspection 14 people were living in the home. This inspection was unannounced and took place on 15 and 16 May 2017.

A registered manager was in post when we inspected the service but was not available at this inspection due to planned leave. 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. In the registered manager's absence a business manager, regional operations manager and senior staff members were available to support our inspection. We spoke with the registered manager on her return so they had the opportunity to add anything further to this inspection.

The provider changed their legal entity in December 2016 from Pilgrim Homes to Pilgrims' Friend Society and this was the home's first rated inspection under this provider. Previously the home had been inspected in December 2013 and was found to be meeting the requirements we looked at.

We found that medicines were not always managed safely. This was evident around the recording of 'As required' medicines where protocols were not always in place to guide staff. One person was not receiving their medicine in line with the directed pharmacy instructions.

We saw that equipment and assistive aids were stored in communal bathrooms around the home which reduced the accessibility of these spaces for people. We observed staff wearing gloves in the corridor before they went in to people's bedrooms to offer personal care which could potentially result in an infection control concern.

The building and décor of the home needed a lot of renovation and was having an impact on the type of care the service could continue to support. The garden was not a secure environment for people who lacked capacity to spend time without the support or supervision of staff. The provider had recognised areas needing improvement and plans were in place to address this.

Although quality monitoring was in place issues around medicine management and recording had not been identified in order for action to be taken prior to our inspection.

People we spoke with told us they felt safe. Staff had the knowledge to identify and act on any safeguarding concerns to keep people safe. One relative told us "My mother has lived here for a number of years now. I'm convinced that had she still been at home, she would not have been alive by now and I'm convinced that, because of the care she gets, she will still be around for a good many years yet."

People enjoyed the choices of food and drink available and food provided met their specific dietary needs. Staff provided good support to those who needed help with eating and drinking. Mealtimes were enjoyable occasions and staff were attentive to people's requests.

People told us they were happy with the care they received and staff were kind and knew them well. People's care was provided in an unrushed manner by staff that treated them respectfully. Comments from people and their relatives included "They make me feel nice and comfortable when I'm in bed and not feeling very well", "If I need a cuddle, someone will put their arm around me", "They always take their time with mum and she's never said to me that she feels as if she's been rushed at all. Everything gets done in her own time these days."

There was mixed reviews on the levels of activities provided by the home. An activity co-ordinator was employed but only worked eight hours a week. The home followed a Christian ethos and some people living in the home practiced a strict regime where they spent many hours reading the bible, in prayer or quiet reflection. People had chosen this home because of their Christian faith and the values the home followed and promoted and some did not want to engage in constant activity that took time away from practicing their faith. Other people however felt the home did not provide enough things for them to participate in.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. Where concerns and complaints had been made these were responded to, investigated and an outcome provided. One person said "I can honestly say that I've never had to raise any concerns whatsoever with the home."

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

This service was not always safe.

We found that medicines were not always managed safely. This was evident around the recording of 'As required' medicines.

We saw that equipment and assistive aids were stored in communal bathrooms around the home which reduced the accessibility of these spaces for people. We observed staff wearing gloves in the corridor before they went in to people's bedrooms to offer personal care.

People we spoke with told us they felt safe. Staff had the knowledge to identify and act on any safeguarding concerns to keep people safe.

Is the service effective?

Good

This service was effective.

New staff completed an induction to provide them with an understanding of their role, and received good support during this time.

People enjoyed the choices of food and drink available and food provided met their specific dietary needs. Staff provided good support to those who needed help with eating and drinking.

People received on-going healthcare support from a range of external healthcare professionals.

Is the service caring?

Good

This service was caring.

People spoke positively about staff and the care they received. This was supported by what we observed.

People were encouraged to remain independent and care was provided in an unrushed manner.

Senior management had recognised the home could further

improve the experience and environment for people living with Dementia and plans were in place to address this.

Is the service responsive?

Good

This service was mostly responsive.

People's care needs and support was recorded and they were involved in planning and reviewing their care plan.

There was mixed reviews around the provision of activities. Some people felt there was not enough available and other's welcomed quiet time to reflect and practice their faith.

People told us they knew how to raise any concerns or complaints and were confident that they would be taken seriously.

Is the service well-led?

Requires Improvement

This service was mostly well-led.

The building and décor of the home needed a lot of renovation and was having an impact on the type of care the home could continue to support.

The garden was not a secure environment for people who lacked capacity to spend time without the support or supervision of staff. The providers were looking into improving this for people and the plan was to rebuild as soon as suitable land became available.

Although quality monitoring was in place issues around medicine management and recording had not been identified in order for action to be taken prior to our inspection.

Staff spoke positively about the management of the home and the support they received.

The provider had recognised areas needing improvement and plans were in place to address this.

Leonora 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.

This inspection took place on 15 and 16 May 2017 and was unannounced. The inspection team consisted of one inspector 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. The provider changed their legal entity in December 2016 from Pilgrim Homes to Pilgrims' Friend Society and this was the home's first rated inspection under this provider. Previously the home had been inspected in December 2013 and was found to be meeting the requirements looked at.

Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with 10 people living at the home, three relatives and visitors, nine staff members, the business manager and regional operations manager. We contacted four health professionals after the inspection and received feedback from one of these professionals. The registered manager was on leave during our inspection and on her return we contacted her to see if they had anything further to add to this inspection.

We reviewed records relating to people's care and other records relating to the management of the home. These included the care records for four people, medicine administration records (MAR), four staff files, the provider's policies and a selection of the services other records relating to the management of the home. We observed care and support in the communal lounge and dining areas during the day and spoke with people around the home.

Requires Improvement

Is the service safe?

Our findings

We observed that medicines were not always well managed. For example, one person had been prescribed medicine to take 'as required' (PRN). We saw staff administer this medicine to the person without first asking if they wanted this. Staff informed us that this person always took their PRN medicine, however this was not administered in line with the prescription directions or by offering the choice to the person.

We saw that staff were not consistent in their recording of an 'NR' (Offered and not required) on people's medicine administration records (MAR) when they had offered PRN medicine and a person had not required it. This meant it was hard to check if people were being offered their PRN medicine by staff. One staff said this had been picked up recently by the regional operations manager. We reviewed the provider's medicine policy and saw it documented "PRN medicines should only be recorded on the MAR when actually given. Offers of PRN medicines that have been refused should not be recorded on MAR."

We saw that protocols for PRN medicine were not always in place for people. We observed that four protocols were missing and raised this with staff who said they should have been done and would be put in place. This meant staff did not have always guidance available to support them in managing people's PRN medicine. For the protocols that were in place there was no evidence that these were being regularly reviewed. We saw some had been in place since January and March 2016. Staff said they thought they should be updated annually. We reviewed the provider policy on reviewing medicines which stated "The interval between medicines reviews should be no more than one year." The protocols had not been updated in line with this policy.

One person had been prescribed medicine that required they received it three times a day. We saw however that this was only being given and signed for once a day. Staff told us that the person refused to have it more than once a day, however instead of documenting that they were still offering it and the person refused they had stopped administering it more than once a day. This had not yet been raised with the GP to check if the person could receive their medicine on a less frequent basis. This meant the home was not administering this person's medicine in line with the prescription directions. One person did not have photo identification on their MAR so staff knew they were administering to the correct person. One member of staff said this person was fairly new but that it still should have been put in place. All other MAR records we saw had photos. The registered manager has since informed us that since our inspection, action has been taken and this has now been put in place.

For people who had been prescribed topical medicines or creams there was some gaps in the recording of these. We asked staff if this was being administered and they told us it was but sometimes staff forgot to sign for it. One member of staff said they had already told staff about this during our inspection as there had been a gap on one person's chart and that they "Were working with staff to think more about the recording." We saw that this had been identified as an issue in the service and a 'Senior cream checklist' had been developed for to ensure they checked the charts daily and could then raise with the individual staff members.

This was a breach of Regulation 12 (2) (g) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that other practices around medicines were practiced safely. The home kept some homely remedies available should people need them (A homely remedy is another name for a non-prescription medicine that is available over the counter in community pharmacies. They can be used in a care home for the short-term management of minor, self-limiting conditions, e.g. headache and cold symptoms). We saw that the GP and pharmacist had signed an authorisation sheet for people in the home to receive these homely remedies should they need to. We observed during one medicine administration round a person did not want to take their medicine immediately but for it to be left by the side of them. The staff member managed this well by encouraging the person to take it but then retreating to a discrete distance to give the person time and space but so they could safely continue to monitor them. One staff member told us when they administer medicines they always started with people's pain relief to ensure the doses were evenly spaced.

Staff told us if a medicine error occurred they checked to see what medicine had been given or missed, informed the senior and recorded this. The home had responded to some near miss errors by reminding staff to use alert cards when administering. If there was a particular dose that had been missed previously an alert card was put alongside this on the MAR's to serve as a reminder to staff. Staff demonstrated that they monitored people for any difficulties in taking their medicine stating that for one person they did not like the format of one of their tablets. Staff spoke with the GP and found out there was another way this person could be prescribed their medicine and initiated getting this changed for them.

We saw that equipment and assistive aids were stored in communal bathrooms around the home which reduced the accessibility of these spaces for people. For example in one bathroom there was a hoist and a commode and in another bathroom three commodes had been stored. One person's walking frame had been left in a narrow corridor upstairs leaving not much room to safely pass through. Staff told us this was because the home afforded little storage space to keep these items safely out of the way.

Staff carried pagers on them so they were alerted when a person pressed their call bell and needed support. Staff explained if this bell was not answered in a timely manner it would go through to the emergency signal. If a person walked with the use of a walking frame staff would detach their call bell from the wall and put it into a bag on the frame so they continued to have this with them when walking about the home or sat in the lounge. One person did not have the capacity to use their call bell and staff told us they made regular checks to this person and a sensor mat and crash mat was in place for their safety. These checks were not however being documented so the frequency of these could not be ascertained.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. Moving and handling assessments documented what assistive equipment should be in place and how many staff were needed to support the person. Interventions were listed including ensuring brakes were applied to beds and wheelchairs, that all necessary items were placed in easy reach and not leaving the person unattended in toilets, bath or showers. It also documented how staff were to undertake care by offering reassurance, not rushing and being patient. Where people were at high risk of falls a risk assessment and management plan was in place. This considered what medicine the person was taking and if this had any impacts on their mobility. For one person that was unable to use a call bell, a sensor mat was in place and a restraint risk assessment had been completed which showed staff understood that this could be form of restraint if the person was unable to understand or consent to it being in place. The person had signed to show their agreement.

The home had a continuity plan in place in the event they needed to evacuate the home and each person

had a personal evacuation form recording the support they would require in this situation. A fire alarm test took place on the second day of our inspection and we observed the maintenance staff informing people this was about to take place so they would not be alarmed. Regular checks were completed in the home including flushing water outlets, water temperature monitoring and physical checks on hoists and wheelchairs.

The recruitment of staff to the home had been a recent struggle and staffing levels had been maintained through the use of agency staff. Agency staff were used that had previously worked in the home and knew people and their preferred routines. One person told us "It would be great if they had someone who could just sit down and talk with us during the day." A relative said "I always seem to see plenty of staff around. When [X] has had to press the buzzer when I've been here visiting her, she's never had to wait more than a couple of minutes for somebody to come along and help sort her out." Staff comments included "We have been low in staff and had a lot of agency. They have started recruiting and they are starting soon", "We have been using a lot of agency lately, we have the same agency staff who know the residents. We do have time to spend with people" and "At the moment we use a lot of agency, it comes and goes. It depends on the shift if we can spend time with people. We always offer a drink and have a chat when doing care." The regional operations manager explained that they used a dependency tool based on the level of needs of people they supported and the registered manager would do observations and raise with their line manager if they felt a person needed more staffing support. At the time of our visit there was reduced occupancy in the home.

We observed after people had eaten their lunch the staff team would then sit in the dining room together and eat their meal. One person told us "It can be very quiet round here and sometimes it is difficult to find someone when you need them." We raised in feedback about the possibility of staggering this staff mealtime to ensure that some staff were still visible or could use this time to spend it with people. The business manager informed us she would raise this with the registered manager and they did encourage staff to eat with people but when there was full occupancy there was not always room in the dining room for everyone to eat together.

The service followed safe recruitment practices. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. This had also been completed for any volunteer members that visited the home and spent time with people. The regional operations manager spoke about staff recruitment saying "We are looking for the right attitude, passion and heart. If they are willing we can train them, so our advertising is aimed at drawing people like that in." We saw that staff files did not contain an identification photo of each staff member. The business manager contacted the companies Human Resources department who informed them this should have been in place. The business manager told us this would be addressed without delay.

People we spoke with told us they felt safe living at Leonora Home and staff were available to help them. Comments included "Yes I do feel safe, it's just comforting to know that help is only a buzzer away", "I kept falling over in my own home, but now I've moved in here, there's always someone around to keep an eye on me and support me when I need it", "I have a buzzer attached to the side of my bed and I never have to wait very long for it to be answered" and "I lived upstairs until February when I had a fall. It was my own fault as I overbalanced and knocked myself on the way down. Once I'd pressed my buzzer, I didn't have to wait very long for help. "One relative told us "My mother has lived here for a number of years now. I'm convinced that had she still been at home, she would not have been alive by now and I'm convinced that, because of the care she gets, she will still be around for a good many years yet." Another relative said "I've never witnessed anything that I was uncomfortable about. My relative has been living here for some years now and she's only ever been treated with kindness by all the staff. I come in at least twice a week, and I have never seen any

staff talking or working with any residents in a way that wasn't very caring and friendly in this manner."

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Staff commented "It's about making sure all the residents' needs are taken care of and they are happy and comfortable and can make choices for themselves. I would report any abuse to the senior or manager and go further if necessary"; "We put residents first and make sure their needs are met. We make sure they can choose what they want as long as there is no risk to them and let them make their own decisions. I would speak to the manager if concerned and we can use external resources" and "We keep people safe. I would speak to my manager, do an incident form, and involve the police if nothing happened or CQC."

We found the service was kept clean and homely. Staff were able to explain how standards of cleanliness were maintained and cleaning schedules were in place to record that all areas of the home were being cleaned. One relative told us "Sometimes my relative's room is a bit untidy, but it's always very clean and I have never smelt anything unpleasant in the entire home since the first time I came through the front door." We observed one shower curtain in an upstairs bathroom was stained and in need of replacing and we raised with senior management to address. At times we observed staff putting gloves on or wearing gloves in the corridor before they went in to people's bedrooms to offer personal care. This heightened the risk for infection control issues and we raised this with senior management to address.

Good

Is the service effective?

Our findings

New staff had a probationary period of training and shadowing another member of staff. Staff comments in regard to their induction included "I had a booklet to go through and was signed off. I did manual handling, fire, food hygiene and then shadowed another staff member until I felt confident" and "They showed me around the home and I spoke with residents at my interview, then did training and shadowed. I did some face to face and online training." We saw that staff files contained an induction record ensuring information about fire and health and safety was given to new starters and this was then signed by their mentor. Competency assessments were also completed during the induction involving manual and handling, infection control and medicines.

We reviewed the staff training log and saw that staff had completed most of the training relevant to their role. Some gaps were evident for housekeeping and catering staff around mental capacity training and this is going to be addressed by senior management. A training plan had been completed up until September 2017 and planned in, Dementia, Safeguarding, dignity and privacy and first aid. Staff told us they had just received their annual refresher training week and were also able to log online and complete some training at home. The regional operations manager told us that during a live ACCTV training programme (ACCTV training is endorsed by Skills for Care) staff can ring in to speak to the expert in the subject, for further clarification or advice. The regional manger also told us that the provider has a Dementia specialist who is driving forward their Dementia strategy across all their homes.

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People were supported by staff who had supervisions (one to one meeting) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. Staff told us "Supervisions are regular or if we have a problem we will speak about it then", "They seem to come around so quick, will speak to manager before if I need to" and "We have appraisals and supervisions with the seniors." The regional operations manager told us "We do quarterly supervisions and ask what concerns do staff have. If there are actions around it we can set up a learning development plan and do more competencies if needed."

The Mental Capacity Act 2005 provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The Deprivation of Liberty Safeguards (DoLS) are part of the Act. The DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom. The registered manager had identified three people whose liberty was being deprived and had made the necessary DoLS applications. These had not yet been approved and authorised. The regional operations manager told us "We make sure we work within the MCA and DoLS legislation, if people can't go out safely, we look at ways of supporting them. We risk assess and see if it is in their best interests and work with them to see if they understand the risks".

We saw that people had signed their agreement to their care and living in the home and having photos taken however these decisions had not always been reviewed as the person's capacity deteriorated to ensure they remained relevant. One person had signed consent to having a lap belt on their wheelchair when they went out and a sensor mat in place yet the person was recorded as not having capacity and would be unable to give informed consent or understand that these were forms of restraint. We saw some good examples of capacity assessments in place, one that considered the times to offer a person personal care in line with their preferences and a best interest meeting had been held involving the person, their family and other professionals. Another capacity assessment looked at the benefits of a person receiving specific medical treatment and how parts of their life were affected by not having the treatment. Senior management informed us that if people are resistant to areas of support such as care or eating, a 'Record of specific decision' is completed with the person and/or their advocate. This assesses the person's mental capacity to make that particular decision and then all involved in supporting this person, share their knowledge in making the decision in their best interests if they are assessed as not having the capacity.

People told us they liked the food and were able to make choices about what they had to eat. Comments included "The food is very nice and home cooked. We had toad in the hole or chicken Kiev today with fresh vegetables. We choose the day before and if we don't like either choice, the cook will make us something else", "It's alright. There's plenty of choice and the puddings are nice. I've put on weight recently from eating too much. My favourite is a nice jacket potato and tuna in seafood sauce"; "The trolley comes round with hot drinks and biscuits every morning, afternoon and evening. We also have juice before dinner and a hot drink after dinner" and "We get a fresh jug of water in our rooms every morning and I have a few snacks of my own if I want them." One relative told us "The food looks very nice and I'm fairly certain it's all home-cooked. My relative doesn't have the greatest appetite, but the care staff try and encourage her to eat little and often and if she doesn't fancy the main meal, the chef will cook her something she does like."

We observed that mealtimes for people were a positive experience with dining tables laid with table cloths, napkins and condiments. A menu was displayed on the wall and people were reminded of the meal choices by attentive staff. People had choices of drinks and vegetables were placed on the table in serving dishes so people could help themselves to the amount they preferred. The food looked hot and appetising and the cook was present in the dining room encouraging people with a second helping and asking if everything was alright. Some people chose to have their meal in their room away from the main dining room and staff delivered their meal on a tray with a protective cover on top. For people that needed support to eat their meal this was done in a respectful manner with staff explaining what the meal was, offering drinks throughout and making conversation with the person. One person did not eat much of their main meal and told staff they did not want a pudding. We saw staff return with a pudding so the person could see and smell it in an attempt to tempt them but the person again refused. A bit later we observed a senior member of staff come and check on this person saying "The girls have told me you haven't eaten much today, are you ok, would you like a supplement drink?" This showed good communication amongst the staff and that people's nutrition was monitored carefully to ensure they maintained a healthy intake.

People's dietary needs and preferences were documented and known by the cook and staff. The home's cook kept a detailed record of people's needs, likes and dislikes including their three favourite meals and three favourite flavour of cakes. A feedback book was in the dining room and people were encouraged to record their thoughts about the food. We were told about one person who had asked about having kiwi fruit and this had then been ordered in for them to enjoy. One person had been struggling to eat some of their food and would remove any lumps. Staff noticed this person was at risk of losing weight and raised concerns with the GP. It was decided to soften these parts of the meal for the person and this had been recorded in their nutritional care plan and the person was happy with this change.

People's care records showed relevant health and social care professionals were involved with people's care. One person told us "I moved in here from my home in [X] and I was able to keep my GP. If I'm feeling poorly, the staff here will usually try and find a way of making me feel better before they call in my GP." Relatives commented "I've found them to be relatively good. They will always call me if [X] is having a bad day, feeling off, or under the weather. I only live five minutes away, so it means I can pop in whenever I need to" and "They will always call and let me know if [X] has been unwell. But I always tell them, if they can't get hold of me and they feel they need to call the doctor out, then they must do so, without having to wait to get my consent." A health professional told us "Other professionals including the memory team, care home liaison, district nurses, Occupational therapists and physiotherapists are all involved as necessary by the home."

We saw that it had been identified that one person had a small pressure wound . The care plan recorded that the district nurse had been informed and a wound care plan was to be implemented. The district nurse had documented it was a vulnerable area and not yet a wound but the home took action promptly and the person was being supported on an air mattress. Air mattresses that were in place adjusted to the person's weight automatically which ensured that the setting remained correct. The regional operations manager informed us that "If someone goes into hospital they have a pack and that goes with them recording their preferences, a pen profile about the person and if a 'Do Not Attempt Resuscitation' (DNAR) is in place." (The DNAR form is a document issued and signed by a doctor, which tells your medical team not to attempt cardiopulmonary resuscitation).

Good

Is the service caring?

Our findings

People told us they were happy with the care they received and staff were kind and knew them well. Comments included "They make me feel nice and comfortable when I'm in bed and not feeling very well", "If I need a cuddle, someone will put their arm around me", "They know how I like my cup of tea and what I like to eat" and "I've made some friends here which is nice. We sit together at meal times. I would say to people to come here." One relative told us "I think the staff know her really well. They never really have to ask her what to do, if she needs help these days because they understand her needs and they just get on and help out with them." Another relative said "Mum is [Age], and every birthday she always gets a beautiful birthday cake baked for her and she can choose what she would like to eat and the chef will do this for her. She's had such lovely birthdays here, that I think for me, it shows just how much they care for their residents." One health professional told us "They are very caring with the residents and know them well."

We saw that staff did not rush people when supporting them. For example, one person was walking with a frame and a staff member was gently supporting by encouraging the person and resting a hand on their lower back. The staff offered to return to the person's room and fetch a cardigan when they remarked that it was cold. Another staff was heard offering a person in their room a book and told the person "I will leave your book here on your table so you can reach it if you want to read it and then you can choose." Staff commented "It's nice and peaceful here, like a big family"; "The best thing about the home is the characters of the residents. We work as a team and there are some good friendships in the home between people living here", "It's a small place and homely, residents and staff get on well, it's welcoming" and "I love it, I get time to see people and chat."

We spoke to the regional operations manager about the suitability of the environment for people who were living with Dementia and were informed that this had been recognised and was being addressed as part of a larger project that was happening across all of the provider's homes. The regional operations manager told us "A Dementia project is being rolled out, which will involve a dementia lead coming in and identifying people who are passionate in the home to drive dementia awareness. There will be training on emotional intelligence and creating the environment. This will look at sensory stimuli to engage with, pictures to talk about on the walls and a cultural change from being less task focused." The registered manager informed us after the inspection that they were mindful "It's an integrated home, not everyone has dementia so we cater to all."

When people moved to the home they were given an information pack which explained about the home to people and its ethos and history. It also provided necessary information about the roles of staff, choice and respect, the complaints procedure, fire procedures and a daily timetable of available events. Weekly events sheets were also given out for up to date information on activities taking place.

We saw that an external hairdresser would visit the home for people who would like this facility. A downstairs bathroom would be used as a makeshift salon during this time. We saw people waiting or in the process of having their hair attended to in the corridor outside this bathroom, some with rollers in their hair or under a dryer. At one point three people were lined up in chairs in the corridor which was not a very

dignified experience for them. Staff explained that the regular hairdresser they use would not normally have that many people outside waiting. We saw a list was displayed in one corridor of people who needed various assistive aids including a lap belt on their wheelchair, a sling and slide sheet for support to move position whilst in bed. We spoke with senior management about this list being visible to all and if this was necessary. We have since been informed by the registered manager that this has now been removed.

Interactions observed between staff and people demonstrated respect. Staff knocked on doors before entering them, asked people's permission before they supported them and checked to see if people needed anything else before leaving them. People and their relatives told us "They always knock on my door each morning and wait for me to ask them to come in", "They always take their time with mum and she's never said to me that she feels as if she's been rushed at all. Everything gets done in her own time these days" and "They are respectful too much sometimes. I wish they'd just pop in and have a chat with me." We saw that a dignity audit had been completed in January 2017 and people were asked questions around being spoken to respectfully, if care was given in a dignified manner and if they had private space. We saw that people had given positive responses to this.

One person told us they had to take showers on certain days commenting "We are told what day and time we can have a shower. Whilst I don't really mind when this happens, it would have been nice to choose for myself." A relative also commented saying "Whilst [X] doesn't necessarily mind, it does seem a bit strange that they are allocated a time and day in the week for the shower or bath. It would be nice if the residents could be asked for their preference themselves, albeit I'm conscious that knowing their luck everybody would want it on the same day at the same time, which I know is not practically possible." We raised this further with staff and were told that people were offered support with showers or baths but it was their choice when this happened. One staff said "Everyone has a wash in the morning and once a week at least they will have a bath or shower if they choose. One person has a shower every day and others prefer not to as much." We saw that personal care records had asked if each person preferred a wash, shower or bath every day, a few times or once a week and recorded this after discussing it with the person.

Other people told us they were able to make choices about their care commenting "I certainly decide what time I get up and go to bed, what I wear and what I eat" and "I can look after myself really, so I just need help mainly with meals, washing and cleaning." One relative said "Mum's never been forced to do anything that she hasn't wanted to do. In fact if she wants to stay in bed until 11 o'clock in the morning, she will do so, but on another morning she may want to get up at 8 o'clock. It's very much up to her and the carers are here to support her in those choices."

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists and staff had received training around end of life care. The registered manager's background was as a palliative care hospice nurse and one senior member of staff told us "We try to keep people at the home and work closely with district nurses." We saw that people had their preferred wishes and preferences for their care at this time clearly recorded in their care plans.

Good

Is the service responsive?

Our findings

The home had recently changed from paper care plans to an electronic format. The care plans contained a detailed front page profile which included important information such as any allergies, daily routine, preferences, relatives involved in care and contact details. People had life histories in place which recorded information for staff to learn more about people and their past experiences. Staff told us "When I'm with people, I ask about them and their past lives and get to know them more" and "I read care plans and talk to residents to find out their preferences. If you ask they will tell you and their family tell us things." Care plans contained personalised information around people's preferred routines. One person's entry stated "I dislike being rushed with my care." We saw that staff recorded daily information about people such as any support they had received and about their wellbeing and mood. The electronic system documented different aspects of a person's care and needs and then linked to any further assessments that had been completed around this. It would also bring up any actions that needed completing such as when a three monthly evaluation was due or a person's eye test.

People's needs were reviewed regularly and as required and relatives were able to be part of this if the person wished. Three monthly reviews were offered but if a person wanted these less frequently this would be noted on their care plan. One relative told us "I always make sure I come in when they are having a meeting about my relative's care. They always include me and I feel like they value my opinions."

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. We observed staff in one handover and saw they communicated well as a team and their discussions demonstrated they knew people well.

There was mixed reviews on the levels of activities provided by the home. An activity co-ordinator was employed but only worked two afternoons a week and after preparation and recording of each activity only two hours on each afternoon was actually spent providing the activity. We found that quite a few people did not leave their rooms and although staff told us this was their choice there did not seem a lot provided for these people to actively engage them. The home followed a Christian ethos and some people living in the home preferred the opportunity for quiet time when they might read their Bible or pray. People had chosen this home because of their Christian faith and the values the home followed and promoted and some did not want to engage in constant activity that took them away from practising their faith, but preferred the quietness of their room. Some people had chosen not to watch television and for this reason the home did not have a TV in the main lounge, instead people could choose to have one in their bedroom if this was their preference. Other people however felt the home did not provide enough things for them to participate in.

We looked at the weekly activity planner and saw that people were offered few opportunities of interest aside from religious activities. Comments from people included "I only really go out when my family take me. I'm not keen on the trips they do here, garden centres aren't really appealing to me anymore", "I often just sit in the lounge all day. There really isn't much to do here other than the prayer meetings and services. We sometimes do some art or a bit of exercise, but that's about all", "I tend to stay in my room because I can

put my radio or television on or just sit quietly here reading my book", "People can visit here anytime. I only really go out when someone comes to take me", "They seem to know when I want to be on my own alright, but are not so good at picking up on when I'd like to chat to someone" , "More activities to do please, the days can be very long here", "I'm very happy here. I like that there is regular bible study as my husband and I did missionary work years ago. I would love others to move in with us here" and "Sometimes, it would be nice, if when staff answer my buzzer, they could stay and have a chat rather than disappearing straight away." One relative told us "A lot of the time, it doesn't seem that there are an awful lot of activities for anybody to take part in. Very often when I come in it is very quiet and people are just sitting in the chairs in the lounge doing nothing."

We saw that people had been offered activities that included prayer meetings, services, devotions, communion, dough modelling, ball games, art classes, crafts and gentle exercises. We reviewed the activity log and saw that the same few people would participate. Four people had received very little interaction from planned activities and their logs showed that in five months they had either received no planned activities or very few from the home's own provision. We spoke with the activities co-ordinator who told us that there was little opportunity to engage in a one to one activity outside of the home as to take one person out for a walk meant their whole time would be with one person and everyone else would miss out and the same opportunity would have to be offered to everyone. The activities co-ordinator further said "There is no plan or budget to increase the hours for the activity person, I personally think it's a full time job. Senior management informed us that management review the activities and budgets are then adapted to suit people's needs.

The activities co-ordinator kept a record of people's responses and was trying to evaluate and find out the things that people were most engaged in. One entry stated 'Although only one person made anything it was enjoyable with conversation and a cup of tea. I must think again how to structure this time.' The activities co-ordinator told us "The joy is in the doing something not the end product. I try and do crafts, music; I go back to what they enjoy. It's such a varied group that it's hard to find an activity that will suit all needs, visual impairments, dementia etc." The activities co-ordinator also said that the timing of providing activities just after lunch when people are sleepy has an effect on the participation levels. An action plan was being written but the activity staff was aware of the constraints the building, budgets and facilities had on the planning. A large room downstairs referred to as the 'Common room' overlooked the front gardens and was a good space that was not always being utilised effectively for people. The room was set up in a formal manner and we were informed this was not really used by anyone other than staff. We spoke to the business manager about using this room to provide activities and encouraging people to engage with the space so they had another place to retreat and spend time in. The registered manager informed us that the room had been used for events including family birthday parties and family support or discussions.

The home relied a lot on a large group of volunteers known as 'Home visitors' who would visit the home regularly and take time to visit people in their rooms and sit and chat or read to them. On alternative weeks one volunteer would do a reminiscence activity and another provided music through playing the piano and singing hymns. Another would put on a fortnightly painting class for people. A voluntary shopper would visit once a week and ask people if they needed anything that they were unable to get out by themselves to fetch and would go shopping on their behalf. One person told us "I don't really have any family living anymore, but I enjoy it when the volunteers come in during the week so I can have a chat with them."

Two outings had been undertaken since September 2016, to a garden centre and a farm for a cream tea. Staff said it was hard to organise and book trips out and people would often not want to attend as it got closer. Staff told us "Some people don't like leaving the home, some went to a farm recently, one person goes out to church every week. People have enough to do, there is something on every day, we have

activities co-ordinator do exercises, singing", "I think people could do with more activities to do, we encourage people to go outside but sometimes only a couple will come out", "They have devotions, holy communion, bible studies. People don't go out much, they go out if they have an appointment" and "They do bible studies, a lot of people don't want to come out of their rooms or want to be overwhelmed with too much." Staff spoke about one person who wrote poems and shared one with other people in the home recently which they enjoyed. Another person would lead the prayer meeting once a week.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. Where concerns and complaints had been made these were responded to, investigated and an outcome provided. People and their relatives told us "I can honestly say that I've never had to raise any concerns whatsoever with the home", "I've certainly got no complaints about how the home is managed. If I need to speak to somebody to find out what is happening with mum, or if I have any particular things I want sorted for her, I can usually find a manager or whoever is the senior on charge at the time I'm in" and "I don't have any concerns, but if I did I'd speak to my daughter about it and ask her to sort it out for me."

Requires Improvement

Is the service well-led?

Our findings

Although quality monitoring was in place issues around medicine management and recording had not been identified in order for action to be taken prior to our inspection. Each month the registered manager would work through the Key Lines of Enquiry (KLOEs). These are used by The Care Quality Commission (CQC) to direct the focus of our inspections, a standard set of key lines of enquiry that directly relate to the five key questions we ask of all services, are they safe, effective, caring, responsive and well-led. The registered manager kept an evidence log to demonstrate how the home was meeting these requirements alongside completing regular audits. A risk rating would be established from these audits and actions set with a timescale to complete these.

Audits that were undertaken included nutrition, infection control, accidents or incidents and medicines. A call bell audit was also completed which comprised of random checks to ensure people had their call bell on or near them. There was not however currently a system to check if call bells were being responded to in a timely manner.

Where a person had experienced a fall an accident form documented this and the registered manager would sign it off after investigating. Falls were looked at for any trends in order to take action and put measures in place to reduce these. The system enabled information around falls to be displayed in a graph portraying people who were at high risk of falls and the location the fall occurred. The regional operations manager told us that further training on the system was needed and this had been arranged in June and July for registered managers.

Provider questionnaires were sent six monthly to people, their advocates, staff, visitors and health care professionals and an analysis of this was given to the home to review. The registered manager completed regular walk rounds of the home and would document this alongside any issues that needed addressing from these observations. The regional operations manager told us the provider had recently been inspected by 'Investors in people UK'. This looked at the standard of people management in the service. The provider had completed a lot of work around their management and leadership and received a silver award for this. The regional operations manager told us they complete a profile to identify strengths and weaknesses in their managers in order to better support them.

The building and décor of the home needed a lot of renovation and was having an impact on the type of care needs the service could provide for. It was not a purpose built home and some of the corridors were very narrow and hard to navigate. Although there was a small lift in place the second floor was only suitable for people who mobilised independently. The rooms were not en-suite and varied in size and the smaller ones would struggle to fit a hoist in should the person require assistance with moving. Staff spoke about the low occupancy in the home and believed this to be a contributing factor especially with newer and more modern homes having recently been built nearby. Staff comments included "They need to improve the building, the rooms are quite small", "We have been told there will be a new home, the rooms are small, it's hard to clean, we have to put chairs in the corridor to clean which isn't ideal", "The building is tired but doesn't interfere with the care and safety, don't judge a book by its cover is what they say", "The toilets need

maintenance and general upkeep. We are first in line for re-building, they are looking for land for us", "Low occupancy, may be because it's a Christian home or not a modern home and there a lot of new homes in the area" and "People say don't look at the home, look at the care." The Registered Manager informed us they were fully aware of the limitations of the building and would only admit people whose needs could be met within the environment. If a person's condition deteriorated, the ability for the home to meet their needs would be reviewed.

The regional operations manager told us "We recognise that the home is not fit for purpose for those requiring higher levels of care and for that reason we are only admitting people, who following assessment, have care needs that can be managed within the limitations of the environment." The home also needed some redecorating and we observed marks on doors and along the corridors there were marks on the paintwork. We spoke to senior management about the upkeep of the home in the interim period of being relocated and were told "The plan is to maintain the home as much as we can until the plans are set, we have a good maintenance team for safe standards and a director of property services." The maintenance staff said "As rooms become empty we decorate, this is on-going, there is no fixed programme, we do it as and when needed".

The gardens available to people were situated at the front of the property with accessible entry onto a busy side road. The garden was not a secure environment for people who lacked capacity to spend time in without the support or supervision of staff. The garden was on a steep incline and there were no grab rails along the path down to the gate. A space just by the front door overlooking the garden had been created with seating area and a gazebo and staff said if people went out they would just use this area. One person said "We sit in the garden in the summer; we have a gazebo just outside the front door. The garden is on quite a slope so we have to be a bit careful. We sometimes get some glorious sunsets as we look out across the West Country." One staff member commented "The drive is steep; it's not much of a suitable path for them." Senior management told us "The garden is not suitable and when it's rebuilt this will be addressed" and "It's not completely secure grounds, this is an area we need to develop next and we are aware of it."

A registered manager was in post at the service but was not available during this inspection due to being on leave. We spoke with the registered manager after our inspection so they had the opportunity to add any further comments. A business manager, regional operations manager and senior staff were available during this inspection. People we spoke with were all aware of who the registered manager was and told us "The manager is usually about, but she's on holiday this week. We have a residents meeting with her every few months where we can ask questions about the home" and "She is usually about here somewhere, but I think she is on holiday this week. She usually stops and has a chat with me most days."

Staff spoke positively about the management of the home commenting "The manager is good, she sits in with us during handovers", "We see the manager about, if have any problems we go to her and she's around on the floor, she's approachable" and "We see the manager all the time, on nights she comes in really early about 4.30am and sees how the shift is. She's pretty much available all the time, she's a likeable person. She is obsessed with getting things right, she does listen and help you, she understands."

Staff attended regular team meetings where information relating to the service would be shared. One senior member of staff said "The girls are so good. We may not have the building but we are homely, I can't praise the staff enough." Staff were able to take on extra responsibilities by becoming the lead in roles including infection control and a qualified handling trainer to deliver manual handling training to other staff. One staff had also taken on the role of getting the electronic care plans up together and senior management told us they looked to identify strengths within the team. The service followed a Christian ethos and promoted an environment for people to embrace and practice their faith within. It was a necessary criteria

for senior management staff to be of Christian faith themselves to ensure the provider's ethos continued to be nurtured.

People living in the home were able to attend regular resident meetings and the Christian ethos remained a part of these meetings with the registered manager opening the meetings with prayers and readings. One person told us "There are residents meetings, three or four times a year and I try to come along to these." An action plan would be created from these meetings if necessary so any concerns raised could be addressed. The business manager informed us of a home newsletter that had been developed commenting "It's a new venture, to keep our friends and volunteers in touch, and I'm happy to note a significant number of staff have signed up by email as well." Printed copies were displayed in the home and the newsletter reported on events affecting the service and one of the volunteers who regularly visited the home had written an article.

The regional operations manager told us the registered manager received monthly or more visits to the home from senior management to support and discuss any events and if necessary put an action plan in place. A monthly report is completed which looks at things including people's weights pressure care and any admissions to the home so senior management can be kept informed of what is happening in the home. The regional operations manager told us "When a manager identifies something they are interested in we support them and they can progress within the organisation. We build up managers and can tap into their knowledge source."

The provider had recognised that the service needed development in areas of dementia care and suitability of the building and plans were in place to address these. The regional operations manager said "There has been investment from the provider to move to electronic care plans to keep them current. We are treating the home as if it is not closing and will invest in it until told otherwise. The development of the organisation is invested in the care of people with dementia and the environment. The chief executive says in order to improve you need to invest, he's listening to us, he wants things to happen."

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always well managed. For medicines to take 'When required' protocols were not always in place. We saw for one person's medicine staff were not administering this in line with the directions stated by the pharmacy. Regulation 12 (2) (g)