Caring Homes Healthcare Group Limited

Ferfoot Care Home

Inspection report

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Date of inspection visit:
02 May 2017
03 May 2017

Date of publication:
08 August 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this inspection over two days on 2 and 3 May 2017. The first day of the inspection was unannounced. During our last inspection in September 2016, we identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We placed a condition on the provider's registration. This required the provider, on a monthly basis, to notify the Care Quality Commission of the action being taken to address the shortfalls identified. The service was rated inadequate and placed into special measures. Special measures provides a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Ferfoot Care Home provides accommodation and nursing care for up to 52 people. At the time of our inspection, 41 people were resident at the home. The majority of people were living with dementia and had complex care needs.

At this inspection, sufficient action had been taken to remove the service from special measures. However, further work was required to ensure a "good" service. In addition, all improvements required time to be properly embedded and sustained.

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

Improvements had been made to people's safety. However, one altercation occurred and we needed to intervene to minimise the risk of harm. Other than this incident, staff were more proactive, identified potential triggers and used distraction techniques to minimise the risk of an altercation. Staff had received additional training to enable them to support people more effectively with areas such as anxiety, frustration and challenging behaviour. Accidents and incidents were more robustly analysed to minimise further occurrences.

Focus had been given to the numbers of staff required to support people safely. Agency staff were used to ensure these numbers were maintained and recruitment was taking place. However, the home was not operating at full occupancy. This meant additional staff would be required to support further people to the service.

Improvements had been made to the cleanliness of the home. This included less visible areas such as the edging of tables. The unpleasant odour, which was identified at the last inspection, had been reduced although remained in some areas. Old carpets, which held odour, had been replaced with laminate flooring. Further replacement of carpets was planned following redecoration.

Care planning had been developed but there was further work to do, to ensure all information clearly reflected people's needs. All information was up to date and had been regularly reviewed. There was an evaluation section within the care plan but this was generally a repeat of information rather than a review of the care being given.

Improvements had been made to the accessibility of drinks. However, staff had not identified one person was unwell and needed greater assistance. Staff were monitoring people's intake more accurately in response to the risks of dehydration and malnutrition. People told us they enjoyed the meals provided and had enough to eat. Menus showed a good choice of food and alternatives were offered according to people's preferences.

Interactions with people had improved Staff were less rushed and had time with people. They were caring in their manner and on the whole, were attentive to people's needs. Focus had been given to people's lives before the onset of their dementia. Information gained had assisted staff to see people differently and develop strategies to ensure effective support. Opportunities for more meaningful social activity provision were being developed. This included activity areas in response to people's history and interests.

People's medicines were safely managed. Staff administered medicines in a person centred manner, giving time and any reassurance required.

The registered manager had increased their presence within the home. They regularly toured the environment assessing areas such as cleanliness and observing staff practice. Staff commented positively about the improvements which had been made. They said management systems were more robust, which helped staff perform more effectively. Such systems included improved absence monitoring and better performance management of staff. Staff felt more supported and were looking to develop further. Focus had been given to staff training, particularly in the area of dementia care. This had helped staff develop a better understanding of the way in which people perceived their world.

There were a range of audits, to monitor the service. These were undertaken at varying frequencies. Action plans were in place to address any shortfalls identified. There was an overall improvement plan, which was developed following the last inspection. The registered manager and senior management recognised a lot of work had been completed but there was more to do. They described the situation as "work in progress".

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.

There were enough staff to meet people's needs although more would be required when the home was operating at full occupancy.

Staff were more proactive in managing potential triggers, which minimised the number of altercations.

Improvements had been made to the cleanliness of the environment although some unpleasant odours remained in certain areas.

People's medicines were safely managed.

Is the service effective?

Requires Improvement

This service was not always effective.

Improvements had been made to ensuring people drank sufficient amounts to ensure their wellbeing.

People enjoyed the meals and had enough to eat.

Focus had been given to staff training, which enhanced the support people received.

People were supported by a range of professionals to meet their health care needs.

Is the service caring?

Good

This service was caring.

Interactions with people had improved.

Staff showed a caring approach and were more attentive to people.

People's rights to privacy and dignity were maintained.

Is the service responsive?

Requires Improvement

This service was not always responsive.

Improvements had been made to the planning and delivery of care. However, further work was required to ensure care plans were sufficiently detailed and person centred.

Clear focus had been given to the development of meaningful social activity, which related to people's individual needs.

People and their relatives were aware of how to make a complaint. Any concerns raised had been properly investigated.

Is the service well-led?

Requires Improvement

This service was not always well-led.

Improvements had been made to the service although further work was required.

The home benefitted from greater support from senior managers and a more visible presence of the registered manager.

The quality auditing systems had been improved and action plans were in place to address any shortfalls.

People and their relatives were encouraged to give their views about the service.

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

This inspection was unannounced on 2 May 2017 and continued on 3 May 2017. The inspection was carried out by one inspector, a specialist advisor in relation to dementia care and one 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.

In order to gain people's views about the quality of the care and support being provided, we spoke with 11 people who use the service and five relatives. We spoke with the registered manager, two senior managers, seven staff and three health care professionals. We looked at people's care records and documentation in relation to the management of the service. This included staff training, recruitment records and quality auditing processes.

Before our inspection, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. In addition, we looked at the 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. The PIR was returned on time and completed in full.

Requires Improvement

Is the service safe?

Our findings

At the last comprehensive inspection in September 2016, we identified the service was not meeting Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people's safety were not being adequately identified and properly addressed. This was a repeated shortfall, which remained outstanding from a previous inspection in May 2015. In addition, the service was not clean, good infection control practice was not always followed and there were shortfalls in the management of people's medicines. As a result of the shortfalls, we placed a condition on the provider's registration. This required the provider to inform us on a monthly basis, of the action they were taking to ensure people's safety. The provider complied with this condition, as required.

At this inspection, improvements had been made to the management of risk. However, one altercation occurred and we intervened to minimise harm. A member of staff was alerted to this, as the person screamed. Whilst they guided the person who had provoked the altercation away, staff did not monitor where they went afterwards. This increased the risk of further incidents. Another person walked around the communal lounge. On one occasion, they took another person's biscuit and ate it as they continued walking. They were then seen with further biscuits. Staff told us this was "usual" behaviour and in response, snacks were left in key positions for them to help themselves. Whilst this was acknowledged, the person's actions of taking food from others increased the risk of retaliation.

On other occasions, staff were more proactive and identified potential triggers, which could provoke an escalation of challenging behaviour. Staff then used distraction techniques before situations escalated. For example, one person began hitting the side of their legs. This showed they were becoming agitated. A member of staff offered distraction by asking the person if they wanted to look at a book with them. The person was then offered a drink and asked if they wanted to go into the garden. The interactions were successful, as the person became settled and appeared content. Another person was encroaching on a person's space. A member of staff encouraged the person to move away, whilst explaining why they needed to do so. Staff guided another person to a different part of the lounge. They said this was because altercations had occurred between this person and another, who was in close proximity.

Relatives told us staff dealt with potential altercations in a calm, discreet manner. One relative said staff reacted quickly but were sensitive whilst doing so. The registered manager and a senior manager told us a lot of work had been done, to enhance people's safety. This included a review of risk assessments, staff training and a thorough analysis of any incidents which had occurred. They said in addition, improvements had been made to find the root cause of people's agitation. The registered manager told us managing potential triggers more effectively, had minimised the occurrence of negative behaviour.

Assessments, which identified potential risks to people's safety, were up to date. Information informed staff of the actions required to minimise such risks. The registered manager told us staff were now much better at reflecting on any accident or incident, which occurred. They said this included considering any changes needed to a person's support and updating care documentation.

Staff were clear about their responsibilities to identify and report any suspicion or allegation of abuse. They said they would discuss any concerns including that of poor practice, with the team leaders, registered manager or senior managers. There were posters around the home, which gave details of whistle-blowing. The registered manager told us all staff initially received "face to face" safeguarding training to ensure an adequate depth of knowledge and understanding. Updated or refresher training was undertaken "on line" or through discussion. The registered manager told us they had a good relationship with the local safeguarding team. This meant they reported and were able to discuss and gain advice about any altercations which took place.

People were relaxed within the vicinity of staff and told us they felt safe within the home. One person told us this was because staff were very "patient and wonderful". Other comments were "safe and happy. Nice room. Find it ok" and "I enjoy living here. It's very good. Safe and alright". One person told us they had been given a key so they could lock their room when they wanted to. They said they were given this as people were entering their room, thinking it was their own. The person told us "I know staff have a pass key, so in an emergency they could get in". Relatives told us they did not have any concerns about their family member's safety. One relative told us "she seems fine. They're very kind to her. It makes her feel safe".

Improvements had been made to the cleanliness of the environment. Whilst there remained some unpleasant odours in particular areas, this was less than previously identified. The registered manager told us many of the old carpets, which held odour, had been replaced with laminate flooring. This meant the flooring was easier to clean and maintain. The registered manager told us new armchairs for the lounges had been purchased and empty bedrooms were being refurbished. There were plans for the communal areas to be redecorated and more carpets to be replaced.

Less visible areas such as the edges and legs of tables were clean. One health care professional told us they had noted the improvements which had been made but explained cleanliness, was something staff needed to "keep on top of" and maintain. The registered manager recognised this and said they regularly monitored cleanliness, as they walked around the home. They said cleaning schedules had been reviewed and staff had worked hard to make improvements. Staff told us there were sufficient housekeeping staff deployed although there were some challenges, when staff were on annual leave. One member of staff told us there were usually four housekeepers on duty although this sometimes reduced to three. They said if an additional housekeeper could be employed, more "deep" cleaning could be completed.

At the last comprehensive inspection in September 2016 we identified the service was not meeting Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because not enough staff were deployed to safely meet people's needs.

At this inspection, the home was relaxed and calm. Staff were not rushed and had time to spend with people. The registered manager told us a review of the numbers of staff required had been undertaken. They said as a result of this, eight staff were needed during the day, to support people effectively. The registered manager told us they worked to this level but on the odd occasion, the home was manageable with seven staff. They said this was not ideal but could occur at times of staff sickness, when all attempts to find cover, were unsuccessful. Records showed staffing levels were maintained at eight staff on duty, with some staff deployed from an agency. The registered manager told us they were actively recruiting new staff to minimise the use of agency staff. However, whilst acknowledging a review of staffing had taken place, the outcome was based on the number of people within the service, which was eleven less, than at full occupancy. The senior manager told us they were aware of this and would continue to review staffing levels as more people moved into the home.

Staff told us staffing arrangements had significantly improved. There were many comments about the staff team being less stressed due to being able to spend sufficient time with people. One member of staff told us "it's so much better. We're not expected to run on less staff. There's better use of agency and we don't have to jump through hoops to get the staff we need". Another member of staff told us "we even have senior managers ringing up now to see if we have enough staff. That's never happened. We all feel better, as we're not as tired. We don't need to do a load of extra shifts anymore and we're not here all the time, like we were before. It's made a real difference". Staff told us other factors such as improved management of staff sickness had improved the situation. Staff were aware any sickness was monitored and they had a return to work interview after a period of sickness. They told us this had minimised unnecessary sickness, which had impacted positively on staffing levels. A heath care professional told us they were unable to comment about staffing levels overall but felt when they visited, sufficient staff were available.

Staff told us the registered manager was actively recruiting new staff and "filling posts". One member of staff said it was intended to improve staffing levels at night by increasing the number of staff from four to five. The registered manager confirmed this and said they were also recruiting for further day staff. Records showed safe recruitment procedures were being followed. This promoted people's safety. All applications contained an application form, evidence of identity and details of the applicant's interview. There were two written references, which commented on the applicant's past work performance and character. A Disclosure and Barring Service (DBS) check had been completed. This identified whether the applicant had any convictions or whether they were barred from working with vulnerable people. A checklist showed when each stage of the recruitment process had been completed. This minimised the risk of anything being missed.

People's medicines were safely managed. There were organised systems regarding the receipt, storage, administration and disposal of medicines. One member of staff administered people's medicines during the inspection. They gave each person their medicines in a way which met their needs. They observed the person take the medicines before signing the medicine administration record. One medicine needed to be checked, administered and recorded as taken, by two members of staff. This was undertaken in line with the provider's policies and procedures. There was up to date guidance about medicines, which staff could refer to at any time. One member of staff demonstrated a clear knowledge of the medicines they were administering. They said some people declined their medicines. In such cases, they said they often returned to the person later rather than causing distress and additional refusal. Another member of staff told us "the medicine round takes as long as it takes. It all depends on the time people take, to take their medicines. We can't rush them as people often need a lot of prompting or encouragement".

Requires Improvement

Is the service effective?

Our findings

The registered manager had an understanding of the Mental Capacity Act (MCA). They said they had undertaken training in the MCA and continued to liaise with the local authority, if they had any queries or needed advice. The MCA provides a legal framework for acting and making decisions on behalf of individuals who may lack the mental capacity to do so for themselves. The Act requires 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 is called the Deprivation of Liberty Safeguards (DoLS). The registered manager had appropriately submitted applications to authorise restrictions for some people. These had been or were being processed by the local authority, the supervisory body.

At the last inspection, people did not always have their drink within easy reach. In addition, those people who were at risk of not drinking enough did not have their intake accurately monitored. Improvements had been made to this area. However, one person's mid-morning drink was untouched and cold. There were biscuits on a plate and a full jug and glass of squash on a table, to the person's side. Staff had not identified the person needed more assistance than usual, to eat and drink. A senior manager told us they would ensure the person's fluid and food intake was monitored, until their health improved. Other people were offered regular drinks of their choice. Records showed staff were monitoring the fluid intake of those people at risk of dehydration. The information identified the person's recommended daily intake. On the whole, these amounts had been exceeded.

Assessments had been taken to identify any risks of malnutrition. Information, showed how such risks were being managed. This included additional snacks, fortified foods and supplements. People's weight was monitored at various frequencies depending on their risk of malnutrition or actual weight loss. One record showed a GP had confirmed a person's weight loss was due to their dementia and it was probable an increase was unlikely. However, records showed the person's food intake was minimal. Whilst recognising the GP's view, there was no evidence of additional snacks or alternatives offered. A senior manager told us they would ensure this was reviewed.

People told us they liked the food and had enough to eat and drink. One person told us "the food suits me alright. Too much at times. Always plenty of food choice". Another person said "it's very good food. We have choice of omelettes, which are good for the hotter days when you don't want heavier types of food". Other comments were "the food is good. You can choose what you want" and "I love my food. It's really good cooking". Relatives confirmed the food was good. One relative told us "he has a good appetite and loves his food".

Staff confirmed meals were generally based on traditional foods, with an emphasis on fresh produce. They said people were able to have a cooked breakfast in various forms, according to their preferences. There was a choice of all meals, with individual wishes taken into account. For example, one member of staff told

us if roast beef or lamb was on the menu, there would also be chicken, as some people preferred this. Another person liked stronger tastes, so their food was always seasoned more than others. Staff told us if people declined a full meal, there were alternatives such as homemade soup. This was confirmed as one person did not want their meal of omelette, chips and peas. They were asked if they wanted their favourite, a cheese salad. Another person was reluctant to eat their lunch. The staff member explained to the person they had not eaten breakfast or their mid-morning snack, so "should eat something". Another staff member told us one person always ate very little but liked milky coffee. They said "I don't mind if they ask for 20 cups a day. It's made with full milk so if they're not eating, at least they're having something". Staff told us people were encouraged to ask or "ring their bell" if they were hungry. One member of staff told us "we try to be creative. One person loves ice-cream so we'll ask if they want some of their chocolate, on the top".

Staff told us they had been an increased focus on their training and development. They said more staff were now doing Health and Social Care diplomas, at varying levels. Staff said they were up to date with their training, which the provider deemed mandatory. They said they had also undertaken other topics. This included end of life care, pressure ulcer prevention and health care conditions such as diabetes. Staff told us their dementia care training had been invaluable. One member of staff told us "it's all about stepping in to their world, not expecting them to come into ours". Another member of staff said "I think we've all learnt a lot. It's definitely helped us manage behaviour better. We now think about how we stand and position ourselves. It's been good". The registered manager and a senior manager confirmed a high level of staff training had been undertaken. They said the organisation had regional trainers so staff had benefitted from "cluster" training. This involved staff attending courses from various other care services, in order to share experiences and learning.

Staff said they felt the training they had completed, had enhanced their practice. One member of staff told us "we think about why we're doing something now". Another member of staff confirmed this. They gave an example of talking to a community nurse about how they supported a person and whether it could have been improved upon. One health care professional told us a member of staff accompanied them, when they undertook a person's consultation. They said this was positive, as it enabled staff to increase their knowledge. However, they felt the learning could sometimes be cascaded to others in a more structured way.

Records showed staff received regular meetings with their supervisor to discuss their work and potential challenges. Whilst these sessions were undertaken on a regular basis, the content was similar and did not promote staff's individual development. There were no goals or targeted action plans. There was a checklist which identified the topics to cover but the majority of sessions had involved staff relationships and communication. This included informing staff of the importance of completing care charts effectively. The senior manager told us they were aware the documented format of the supervision sessions could be improved upon. They said this would be looked at, as a future development.

People told us they were able to see a GP if they wanted to. They said they also saw a chiropodist, optician, district nurse and dentist, when required. One person told us they had recently been unwell with a chest infection. They said had seen the GP and had been sent for an X-ray. Records of all healthcare appointments and interventions were maintained. Staff told us they had been trained to undertake basic baseline observations to assist health care professionals with a diagnosis. They gave an example whereby one person was recently unwell with increased confusion, lethargy and a decline in appetite. Staff had taken steps to record the person's temperature, blood pressure and urinalysis results before contacting the GP, for support.

Staff told us the home had developed good relationships with local surgeries. They said GPs did a regular

"round", usually on a Monday, where they saw anyone of concern. Staff told us this system worked well, as any ill health could be discussed and acted on quickly. One member of staff commented the system had ensured continuity and follow up, to any treatment prescribed. Another member of staff told us the visits, minimised the risk of unnecessary hospital admissions. On the day of the inspection, two GPs were routinely visiting people. The registered manager told us in addition to GPs, a member of the Care Liaison team visited on a weekly basis or more frequently if required. They told us this was invaluable to discuss particular issues such as any deterioration in a person's mental health or challenges with anxiety and associated behaviour. Staff said specialist services were accessed as required. This included the Speech and Language team, community physiotherapy and occupational therapists.

Good

Is the service caring?

Our findings

At the last comprehensive inspection in September 2016 we identified the service was not meeting Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because practices did not always promote people's privacy and dignity.

At this inspection, improvements had been made to this area. Staff were less stressed than at the last inspection and interactions with people had improved. Staff were caring and respectful in their approach. They were attentive and gave people time to engage in conversation. Staff acknowledged and spoke to people, as they walked through the communal areas. This included "hello X. Lovely sunshine today". One member of staff sat next to a person on a sofa, whilst assisting them to eat. The person was leant into the staff member and looked comfortable and content. The staff member spoke to the person in a quiet tone about aspects such as the weather. They checked to make sure the person was happy with what they were eating. The person was relaxed and settled although had previously spent much of the day, walking around the communal areas of the home. On the first day of the inspection, the person had been assisted to eat their meal whilst standing up, due to their agitation.

One person walked into the care office, as if they were looking for something or someone. A member of staff greeted the person and asked if they could help. They then said "we can go together X, would you like me to come with you?" The person took the staff member's arm and the person was distracted, as they talked about the tea, which was being prepared. Another person pointed to a member of staff across the lounge. The member of staff waved back and said "alright X?" The person nodded and smiled. Another person was worried as they were unsure where they were. A member of staff was reassuring and placed an arm around the person, as they walked along the corridor.

Staff were confident when talking about how they promoted people's privacy and dignity. This included being sensitive when supporting people with their personal care and ensuring people were dressed appropriately. One member of staff told us how they directed people away from others if they were becoming anxious or upset. They said they tried to be discreet so people did not see any escalation, which would compromise their dignity. Another member of staff told us a person used a 'childlike' substitute of porridge due to their swallowing difficulties. They said the mixture was taken out of the box, so attention was not drawn to its name or manufacturer. People confirmed their privacy and dignity was maintained. One person told us "they do knock on my door and wait till I get there to let them in". Another person said staff spoke to them "nicely". There were various occasions during the inspection when staff promoted people's privacy and dignity. This included a member of staff quickly wiping a person's mouth after some of their medicine dripped, whilst they took it from a spoon.

People were complimentary about the staff. Specific comments included "the carers are wonderful", "they are good carers. They look after me fine" and "staff do respect you. They treat you with care and kindness". One person told us "staff are very caring. I've been here for a long time and have never seen any of them run out of patience". Another person said staff were "lovely" when they responded to their call bell. Relatives were equally positive about the staff. One relative told us "when X came here I was very stressed but we'd

fallen at the feet of angels. The staff were amazing and spoke to X, as if they'd known her for ages. She responded to this, which I know helped her settle". The relative continued to tell us "they know my mum as X [the person's name] and they know what she likes down to the tiniest detail, like making sure she has her perfume on. They really have a connection with her. I think they're great". Other comments from relatives included "I have nothing but praise for them" and "the staff are very respectful towards people". One relative told us staff were "brilliant" at looking after them, as well as their family member. One staff member was seen holding a relative's hand, whilst talking and reassuring them.

Requires Improvement

Is the service responsive?

Our findings

At the last comprehensive inspection in September 2016 we identified the service was not meeting Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the planning and delivery of care did not ensure people's needs were effectively and safely met.

Improvements had been made to people's care plans. However, there was further work to do to ensure all information fully reflected people's needs. For example, one person had contracted limbs. Their care plan stated the palm of their hand could become sore because of this. If a wound appeared, the guidance for staff was to inform the community nurses. There was no information to inform staff of the care the person's hand required. Another record showed the person disliked having their teeth cleaned and would decline assistance. The information did not show how their resistance was to be managed. One care plan stated the person experienced constipation and urinary tract infections. There was no guidance for staff as to how they could support the person to minimise these conditions. Staff had not documented any information about one person being unwell and needing additional support with their eating and drinking. This increased the risk of staff not being fully informed of the person's needs. In addition, it did not enable accurate monitoring of the person's health. A senior manager confirmed on-going work was being undertaken to develop care plans and ensure all information accurately reflected people's needs.

Care plans had been regularly reviewed. A one page profile, which gave a summarised account of the person's needs, had been introduced. However, the evaluation section of the care plan was generally a repeat of information. It did not show whether the measures in place, were effective to meet the person's needs. For example, one care plan stated the person experienced a high level of pain. The evaluation section instructed staff to continue administering the person's pain relief, as stated on their medicine administration record. The information did not show an assessment to determine if the person's pain relief was sufficient and given at the most appropriate time. Another record identified a goal of ensuring the person maintained their weight. The evaluation section did not show any amendments to the care plan had been made, despite the person's weight slowly decreasing. Another person was regularly monitored to minimise the risk of an altercation. Staff had documented they had seen the person on a half hourly basis but no other detail was stated. This did not enable accurate monitoring of the person's mood or activity. Another record showed a person had sustained a fall. Further information stated they were unsettled and shouting and hallucinating. Staff had recorded they had checked the person regularly but had not stated any action they had taken. Records did not show a potential association between the person's agitation and their pain.

At this inspection, staff were more attentive and responsive to people's needs. However, there were some interactions which could have been improved upon. One person was walking in the lounge and a member of staff asked "are you alright X?" The person replied "no" but the member of staff did not stop to find out why. The registered manager told us "no" was the person's usual response and this did not express unhappiness. They said due to this, it was not always relevant, for staff to question the person further. Staff asked another person if they wanted to assist them with returning the trolley to the kitchen. The person agreed but the staff member did not wait for them. The person continued to walk through the lounge in the opposite direction.

Another person was tapping and feeling their way along a wall. A member of staff walked towards them but quickly left through an adjacent door. The person responded by becoming agitated and rattling the door to follow.

Other interactions were much improved. One member of staff asked a person if they could take their blood pressure. They fully explained the procedure and then talked through each step, as it took place. This included "you'll feel it going tight on your arm X. Now it's going tighter and tighter. How you feeling? Are you alright?" Another member of staff identified a person had finished their drink and were precariously holding the cup with their finger. They asked the person for the cup but the person was reluctant to give it to them. The member of staff explained they would wash the cup and bring it straight back, filled if this is what they wanted. The person smiled and willingly gave the member of staff the cup. Another member of staff identified the television was on in the main lounge but the channel was not appropriate. They asked people if they wanted the television turned over or whether they wanted to listen to some music.

The registered manager told us a lot of work had been done to find out about people's previous history. This included details of family, previous occupations, hobbies and personal preferences. The information had been transferred into "engagement" booklets. This had enabled staff to become familiar with each person's past, before living with their dementia. The registered manager told us this insight had been invaluable in understanding each person. They said it had also enabled staff to see people differently and understand individual attitudes and mannerisms. The registered manager told us they had been invited by one relative to visit their home, which they shared before their partner's admission to the service. They were able to see the person's conservatory and summerhouse, which they had built.

Staff had engaged with this piece of work and explained some people's history. They told us one person had run marathons and another was a keen sailor. In addition to talking to people about their past, staff said social activity areas, had been developed. The idea of these had been gained from dementia care training, staff had completed. One area, contained a bible, prayer books and other religious objects in response to a person's faith. Another area had a small washing line, with pegs and clothing. There were a range of different knots and nautical themes displayed on one wall. This was intended for the person who had previously enjoyed yachting. One member of staff told us if the person appeared agitated, they asked them to tie a particular knot. They said this was a useful distraction, which was usually successful.

During the inspection, some people were having their finger nails manicured and a musical activity known as "Oomph" was taking place. Whilst some people took part and looked as if they were enjoying the activity, staff told us they had recognised group activity was "not for everyone". As a result, a range of meaningful, one to one activities had been developed. For example, one person was being assisted to clean and polish a pair of men's boots. Discussion was taking place regarding what the person used to wear and for what purpose. Another person was assisted to make sandwiches. A relative told us about "Fruity Friday". They said a range of fruits, often those more unusual, were purchased and people were assisted to cut them up. People were then encouraged to eat the fruits and talk about the flavours and textures. One person was looking at a gardening book with a member of staff. The member of staff was making conversation and asking questions such as "did you used to buy your wife flowers?" Another member of staff asked a person if they wanted to help them with the drinks trolley. The person pushed the trolley and gained encouragement from staff, as they did so. After a while, the staff member encouraged the person to take a break. They laughed and said "if you don't they'll make you work all day".

There were positive comments about the activities available to people. One person told us "I join in with the exercise, entertainment, church services and gospel singing". Another person told us "I love colouring, music and singing. They sing here. There's quite a bit of variety". Other comments were "I join in with anything.

There's always some activity going on", "I like the exercises. They keep me going" and "I like the trips to the sea-side. We have fish and chips on the front". Some people told us they liked the garden and spending time outside. Relatives confirmed there was a good selection of activities their family members could join in with. One relative said staff helped their family member continue with their interest of making and decorating cakes. Other activities provided were quizzes, reminiscence, craft sessions and skittles. Relatives and staff told us entertainers were invited to the home and external activities such as visits to local garden centres and meals out, took place. In addition, themes and key events such as Burn's Night were celebrated. They said local clergy from various denominations visited to provide services or individual support to people.

People and their relatives knew how to raise a concern. One person told us they would "tell anyone", if they were not happy. A relative said "we have had some worries and concerns but we had discussions with the manager". Another relative told us "the team leader is always saying, any problems go to her". One relative told us they had spoken to the manager as they were concerned some aspects of their family member's care, were not being done. They said this was properly addressed and there had been no further concerns. Other people and relatives told us they had not had cause to complain.

The home's complaint procedure was clearly displayed. This showed who to raise a concern with and what to do if it was not properly resolved. Records demonstrated the complaints received had been fully investigated. Those which had been substantiated showed clear action had been taken, to address any shortfalls. One member of staff told us "no one likes complaints but we always encourage people to say, then we can sort it out". The registered manager told us they aimed to meet with anyone who was not happy with the service they were receiving. They said discussing issues "face to face" was helpful and enabled concerns to be addressed more easily.

Requires Improvement

Is the service well-led?

Our findings

At the last comprehensive inspection in September 2016 we identified the service was not meeting Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because audits were not effectively identifying and addressing shortfalls.

At this inspection, improvements had been made to the monitoring of the service. A range of audits had been more thoroughly implemented. Shortfalls were being identified and action plans were in place. Areas such as health and safety, infection control and medicines were being regularly checked. Records showed there were also observational audits. These included how staff spoke to people and the interactions that took place. However, within one audit, it had been identified people's beds needed to be made at a reasonable time. At lunchtime during the inspection, some beds had been stripped but not remade. One relative told us this made the room untidy but more importantly, did not enable their relative to have a rest on their bed, if they wanted one. The registered manager confirmed they now analysed accidents and incidents more robustly. This included contributory factors, which were addressed to minimise further occurrences. The registered manager told us as a result of the increased analysis, the number of accidents and incidents had decreased.

During the inspection, the registered manager had a presence in the home. They had various conversations with people and assisted one person to eat their lunch. The registered manager told us they regularly walked around the home, to check on people's wellbeing, the standard of cleanliness and staff practice. They said the first check was undertaken at around 8am. This enabled any issues to be discussed at the 'heads of department' meeting at 8.45am each morning. The registered manager told us these meetings were held to discuss key issues and to remind staff if any tasks needed to be completed.

Staff told us the improvements in the service had been helped by greater involvement from the registered manager and senior managers. One member of staff told us "X [the registered manager] is on the floor a lot more and is more aware of what's going on". Another member of staff confirmed this and added "we had to swallow our pride and admit things weren't going well. Now though X [the registered manager] is dealing with things more, so staff are working how they should be. We're all performing better". The member of staff told us they felt staff were now more accountable and processes such as the disciplinary procedure were used more robustly. Other staff told us they felt more involved in the management of the home. They said they had been shown the home's improvement plan and regularly discussed how it was being implemented. Staff told us they saw more of senior managers, than they did before. One member of staff told us "they are more engaging and listen to our moans and groans". Other comments were "it's been drilled into us, why we need to complete the care charts. I think that understanding has helped" and "residents deserve good care. I didn't feel we were giving that but we are now. It's so much better". One person told us "we see the manager. She always speaks and calls you by your Christian name". A relative told us "we have quite a lot of contact with the manager".

Staff told us the home was now calmer and people were more relaxed. They said this was predominantly due to having more time with people. One member of staff told us "it is nowhere near as hectic. We could

see people were more likely to get upset if they were not doing anything but it was really difficult. Now we have time with people to either sit and chat or do something with them". Another member of staff told us "activities are everyone's responsibility and need to be part of a person's day. If people are occupied, they have less chance of being bored and agitated".

The registered manager told us staff had worked hard to make improvements to the service. A senior manager confirmed this and said there had been a shift in the culture of the home. They said the management team had been helping staff to think about things differently, in a planned way. This included encouraging staff to reflect and think "how would I feel?" and "what can I do to prevent X from happening". The senior manager and registered manager told us whilst improvements had been made, it was still "work in progress" and there was further work to do.

Staff told us improvements had been made to the level of support they were given. One member of staff told us "I feel we're much more supported now. Our opinions are held in better regard". Another member of staff told us "management are much more involved so they know what it's like on the floor. It can be hard but we're able to have "time out" if needed and someone else will take over". One member of staff told us their stress levels had reduced significantly. They said "we're on the way up. It's a lot better. I think the staff feel much more valued now".

Whilst it was recognised during the inspection that the deployment of staff had improved, the home was not operating at full occupancy. This meant there were eleven less people than the number who could be accommodated. A senior manager confirmed staffing levels would increase, as new people were admitted to the service. They told us to ensure improvements were sustained and continued, new admissions to the service would be carefully considered. They said these would be staggered to ensure any additional pressure was minimised. In addition, the complexity of a new person would be robustly assessed and the impact of them on others, considered. The senior manager told us they were aware it only took one person to "tip the balance" and have a negative impact on the service.

People and their relatives told us they were encouraged to give their views about the service. This was informally, within meetings or by completing surveys. A senior manager told us they were looking at renaming particular areas of the home, currently called the 'old' and 'new' wing. They said people and their relatives would be asked to suggest names and a decision would be made from these. The senior manager told us they were looking to further develop people and relative's involvement in the running of the home. The registered manager told us to give support and enable further discussion, sessions in relation to dementia care, were arranged for family members. These had been positive and had increased understanding in the condition and its management.