Anchor Trust

Thornton Hill

Inspection Report

Church Road
Thornton in Craven
Tel: 01282 842023
Website: www.anchor.org.uk

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Summary of findings

Overall summary

Thornton Hill is a care home which provides accommodation and personal care for up to 45 adults. The home is a converted manor house and is split into two units, the main unit which provides elderly residential care and a unit, designed to specifically accommodate people living with dementia. The home had a registered manager in post and we found all required notifications had been reported to the Care Quality Commission. On the day of our inspection there were 40 people living in the home, 21 people living in the main unit and 19 in unit for people living with dementia. The service had a registered manager in post.

The overall feedback about the quality of the home was positive from people who used the service and their relatives. For example, people told us they were happy at the home and they particularly liked the food on offer. People said they felt safe and that staff treated them well. People and their relatives commented that they would like more activities to be available.

Staff, people who used the service and their relatives all told us there were not enough staff at the home. The home struggled to meet its target staffing levels on 11 out of 21 days in April 2014 due to a lack of bank staff to cover regular staff absences. Even when target staffing levels were met, such as on the day of the inspection, the planned staffing levels combined with the layout of the building meant there were times when staff were unable to supervise communal areas accommodating people with behaviour that challenges, putting them at risk. We observed times when people were not provided with prompt assistance or regular interactions meaning that their needs were not always met. The problems we found breached Regulation 22, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

The home had systems in place to keep people safe with staff aware of the key risks identified and how to protect people from harm. Risks to people were assessed and where incidents did occur, they were investigated and action taken to reduce the risk of further harm.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes and hospitals. There were no Deprivation of Liberty Safeguards (DoLS) orders in place and staff had received training on DoLS. We did not observe any restrictions of people's liberty during the inspection. Staff understood how to protect the rights of people without capacity who could not make decisions for themselves.

People were able to make choices in relation to their daily lives, for example choosing what they wanted to do and staff respected these wishes. Staff were familiar with people's individual needs, wishes and preferences, demonstrating they understood the people they were caring for.

Care plan documentation showed people's needs were assessed and was sufficiently detailed to allow staff to deliver effective care. The completion of end of life care documentation required improvement to ensure people's end of life preferences were recorded.

Staff were caring and compassionate and treated people with dignity and respect. The interactions we saw between staff and people who used the service were positive and this reflected in the feedback people and their relatives gave to us. A health professional who regularly visited the home told us staff were caring and supportive and that they would have no problem recommending the home to a relative.

People and their relatives were involved in the planning and review of care through regular care plan reviews and resident meetings.

Communal areas were spacious and comfortable. Two baths in the unit for people living with dementia were currently out of order due to maintenance issues which meant people had to get a shower or make the trip over to the main unit in order to get a bath. The environment in the unit for people living with dementia was bland with a lack of features to aid people living with dementia such as clear signage.

People who used the service and staff spoke positively about the manager and said they would effectively address any concerns they had and provided feedback about any improvements made to care as a result.

Summary of findings

Systems were in place to allow the home to learn from incidents and continuously improve through audits and working to a service improvement plan.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

People said they felt safe in the home. They said they were able to do what they wanted within the home with no unnecessary restrictions on their freedom.

The home regularly failed to maintain its target staffing levels and this posed risks to people as it meant some areas of the home could be left unsupervised and people not attended to promptly. The layout of the building also posed significant challenges to safe staffing levels and because of the various communal areas, even with the target staff numbers in place, there were instances when communal areas accommodating people with challenging behaviour were not adequately supervised. At times people were left without interaction and response times to call buzzers was unacceptably long and were left unanswered for up to 15 minutes. Staff, people who used the service, relatives and a visiting health professional all told us that the service needed more staff.

Recruitment procedures were in place to ensure staff were suitable for the role and effective disciplinary procedures to ensure any instances of poor or unsafe staff practice were promptly addressed.

Staff had a good understanding of how to identify and act on allegations of abuse to keep people safe. Staff had received training to give them the skills to do this. Staff understood how the Mental Capacity Act (MCA) was applied to ensure decisions made for people without capacity were made in their best interest.

CQC monitored the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes and hospitals. There were no Deprivation of Liberty Safeguards (DoLS) orders in place and staff had received training on DoLS. We did not observe any restrictions of people's liberty during the inspection.

We saw instances of behaviours that challenge that were dealt with effectively and calmly by staff before they escalated, to ensure people were kept safe.

An effective incident management system was in place which ensured all incidents were reported to management, so the management could take action to keep people safe.

Significant risks to people were assessed and documented to ensure staff knew how to provide care and support in a safe way. This included task specific risk assessments for example to enable someone to smoke safely.

Summary of findings

Are services effective?

People and their relatives told us they could express their choices and preferences and staff respected these views, for example in the time they got up in the morning.

Care plans contained information about people's choices and preferences so that staff knew how to meet people's individual needs. People's needs were assessed in a number of areas such as nutrition and mobility to enable staff to deliver effective care.

Staff were able to tell us about people's individual needs, preferences, likes and dislikes, demonstrating staff had a good understanding of the people they were caring for. A programme of staff training was in place to ensure staff were up-to-date with a variety of training topics to ensure they had the skills to meet people's needs. The service had plans in place to provide more specialist training so staff had more specific knowledge in areas such as nutrition.

At the time of the inspection nobody at the home received end of life care although the manager was able to tell us about the advanced preparations they had made for one person. End of life documentation was available for people to communicate their end of life preferences, however this had not always been completed. Most staff had not yet received training in end of life care, however we saw plans were in place to provide this training to ensure staff knew how to deliver appropriate end of life care.

The home was spacious and comfortable with various communal areas where people could spend time. Two baths in the unit for people living with dementia were currently out of order due to maintenance issues which meant people had to get a shower or make the trip over to the main unit in order to get a bath. Staff told us these had not been working for several months. The unit for people living with dementia could have been better adapted to meet the needs of people with dementia, for example with more signage, pictures and personalisation. Staff and the manager were not aware of any guidance in relation to environmental design for those living with dementia.

Are services caring?

People and relatives overwhelmingly told us the organisation and its staff were caring and that they were treated with dignity and respect. A visiting health professional also told us staff were kind and caring and treated people with dignity and respect.

Summary of findings

We observed care and saw interactions between staff and people were positive, with staff caring and cheerful, supporting people to undertake tasks but also enabling them to be as independent as possible.

Staff understood how to ensure people's dignity was maintained, for example when transferring people via the hoist. Staff told us they had all received training in how to care for people living with a dementia and were able to tell us how they had put this training into practice in ensuring caring and appropriate interactions with people living with dementia.

The main concern raised by staff was with regards to delivering appropriate care was that due to staffing numbers they were sometimes unable to engage in prolonged conversations with people for example about their life history.

The service liaised with other healthcare professionals regarding the provision of end of life care, and their advice was recorded to enable staff to deliver appropriate end of life care.

Are services responsive to people's needs?

People and their relatives told us they were involved in care plan reviews in order to plan long term care and support. People and their relatives said that they would prefer more activities as sometimes there wasn't enough to do at the home.

Care plans considered the support people needed to help people make decisions for themselves. Processes were in place to ensure decisions made for people with limited capacity were made in their best interests.

A health professional who regularly visited the home told us that they thought the service was responsive to people's needs and that staff were pro-active for example in identifying pressure area damage and referring appropriately. They told us staff followed their advice and provided good quality care.

We observed people were asked for their views and actively involved in decisions which related to their day to day support such as what they wanted to do.

Care records clearly documented how to ensure people were effectively communicated with to allow them to voice their options and be involved in decisions. Daily care records showed that staff documented choices given to people, for example regarding personal care and there was evidence people's wishes had been respected included where they had refused assistance.

Summary of findings

People and their relatives were involved in the planning of their care and support through regular review meetings and their views were recorded. Views on care had been clearly recorded, and we saw evidence that changes had been made following review meetings.

Care plans were in place which enabled staff to deliver care that met people's individual needs for example in meeting their personal hygiene needs. One person's care plan was missing information on their emotional and psychological assessment despite having being referred to the GP due to concerns over their mental health.

We found staff did not always have the time to spend with people although all basic care tasks were carried out. For example, on observing care in the unit for people living with dementia we saw some people were left for up to an hour without any interaction. Staff told us they often did not have enough time to spend with people.

People said they were comfortable raising concerns. The home was good at logging and responding to informal complaints and comments as well as formal complaints so that even minor issues were identified and acted on.

Are services well-led?

People and their relatives spoke positively about management at the home and said they were open and dealt with their concerns effectively.

Staff also had confidence in the manager and said they would listen and act on any concerns that they raised. There were mechanisms in place to log staff views, comments and concerns and evidence they had been acted on appropriately.

The provider had a well understood set of values, aims and objectives which the staff and management were all aware of which they were told about regularly through the provider's corporate training programme.

There was a consistency between what staff and management said were the key challenges to the organisation. Staff and management both acknowledged that maintaining target staffing levels and ensuring staff morale should be improved.

People who used the service and their relatives were involved in the running of the service through regular meetings. There was evidence that actions had been taken to act on people's views such as planning activities that people had requested. This indicated that people were listened to.

Summary of findings

We found effective systems were in place to log, investigate and learn from incidents and complaints. This included a lessons learnt document which was completed by the manager following each incident to ensure the organisation improved its practices.

The provider did not use a formal tool to determine safe staffing levels, which considered the dependency of people who used the service, instances of challenging behaviour or the layout of the building. This meant there was no system in place to determine if the service had safe staffing levels.

A programme of regular audits were conducted by the home manager and regional manager to identify risks. We saw evidence that action plans had been produced following audits and the manager had worked through them to continuously improve the service.

Summary of findings

What people who use the service and those that matter to them say

During the inspection we spoke with eight people who used the service and two relatives, face to face. People told us they felt safe in the home. One person told us "I've never not felt safe."

People said they were happy with the care received and that staff were caring and kind. One person told us "Staff are lovely," another person said "I think I made a good choice" and third person said "I'd say it was first class really."

People said the food was particularly good at the home. One person told us "The food is unbelievable."

Most people and/or their relatives said their care plans had been discussed with them, although one person could not remember if it had.

People and their relatives said that there needed to be more staff in the home as staff were rushed and did not always promptly respond to their needs. One person told us "Sometimes they are a bit short staffed" and another person said "They're pushed at times and could do with one or two more."

People said that they thought more activities should be provided. One person told us "They don't organise a lot" and another person said "There are not many activities organised."

People said the manager was approachable and was good at dealing with any problems raised. One person said "I speak to the manager if anything bothers me."

Thornton Hill

Detailed findings

Background to this inspection

Thornton Hill is a residential home providing elderly care and is run by Anchor Trust.

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

We visited the service on 22 April 2014. We used a number of different methods to help us understand the experiences of people who used the service, including talking with people, observing the care and support being delivered and looking at documents and records that related to peoples support and care and the management of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

The inspection team consisted of a Lead Inspector and an Expert by Experience who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience gathered information from people who used the service by speaking with them face to face in detail.

Before our inspection, we reviewed all the information we held about the service and contacted the local authority commissioning team. On the day of our inspection, we spoke with eight people who used the service, two relatives, one health professional, one other visitor and seven members of staff.

We last inspected the service in August 2013 and found them to meet the required standards in the three areas we looked at.

Are services safe?

Our findings

Prior to the inspection, we received an anonymous complaint which stated staffing levels were insufficient and this impacted on people's safety in the home. We spoke with the manager about staffing levels. They told us that they aimed to have six carers and two team leaders working the dayshifts at the home. That was split between three carers and one team leader in the main unit of the home and three carers and one team leader on the unit for people living with dementia.

We found the current staffing levels posed a risk to people's safety across both units of the home. The service regularly did not regularly achieve its target staffing levels. We looked at staff rotas for April 2014. On 11 out of 21 of these days, the service had not achieved six staff as per its target on at least one of the daytime shifts. The manager told us they had recognised this problem and said that they were in the process of recruiting staff and that their current staffing levels meant that when regular staff were absent; they struggled to meet the staffing target due to a lack of bank staff. All staff and team leaders we spoke with told us that staffing levels were not sufficient and that this was a problem across both units of the home. They confirmed to us that the service regularly struggled to achieve its target staffing and this posed a risks to residents. They said that this sometimes resulted in only two carers on one of the units, which meant that if someone required two person care, other residents were not supervised and if an incident of challenging behaviour occurred they sometimes struggle to contain it quickly as there were not enough staff to de-escalate the situation.

Staffing levels were not based on the dependency of residents, prevalence of challenging behaviour and layout of the building. Some staff told us that the dependency level of residents on the residential unit had risen but staffing had not changed to take an account of this. We spoke with the manager about how staffing levels were calculated, they said there was a tool available but it had not been recently used. The manager admitted that the tool would not take account of the layout of the building and that the layout presented challenges with regards to safe staffing levels. Staff raised concerns with us that even with six staff as per the target, the increased dependency of residents on the main unit and incidents of challenging behaviour on the unit for people living with dementia people were sometimes put at unnecessary risk. For example, staff told us they were supposed to supervise the two communal areas of the unit for people living with dementia at all times but because the communal areas were spread over two floors there were times when one of these areas were left unsupervised putting people at risk.

Most people who used the service that we spoke with told us that staffing levels were insufficient at times and that they sometimes had to wait for care or assistance. A visiting health professional told us their only concern with the home was that staffing levels were insufficient at times and confirmed people often had to wait for assistance.

Although team leaders were present on each floor to assist staff, our discussions with them and other staff found that due to management tasks they had little time to be involved in routine care and as such were not always able to ease the pressure on care staff.

On the day of the inspection there were six carers and two team leaders working at the home. We found staffing levels were stretched and it was difficult for staff to always supervise all the communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

On the unit for people living with dementia we observed periods of time of up to an hour when people were left without interactions. There were several periods of 5-10 minutes when one of the communal areas in the unit for people living with dementia were not always occupied. This meant that should challenging behaviour occur staff may not be at hand to defuse the situation. During the day we observed some call buzzers took a significant amount of time to be answered, for example one person's buzzer was ringing for 15 minutes before staff came to assistance. A member of staff told us that it often takes 20 minutes to answer a call bell. This indicated that there were insufficient staffing numbers.

The problems we found breached Regulation 22, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Safe recruitment procedures were in place, which ensured staff were suitable for the role. Application forms,

Are services safe?

interviews and DBS (Disclosure and Baring Service) checks and references were undertaken before staff started work. The staff we spoke with confirmed these checks had taken place before they started work.

Disciplinary procedures were in place and we were shown examples of how the disciplinary process had been followed where poor working practice had been identified. This helped to ensure standards were maintained and people kept safe.

We spoke with eight people who used the service who told us they felt safe in the home and they did not raise any concerns with us regarding their safety. For example one person told us, "I've never not felt safe." People said that their freedom was not restricted and they were able to do what they wanted within the home.

We saw evidence the provider had safeguarding policies and protocols in place designed to protect people from harm. Staff were able to describe to us what constituted abuse and the actions they would take to escalate concerns in order to keep people safe. Staff told us they had been on safeguarding training which teaches the skills to identify and act on abuse. We saw evidence which confirmed safeguarding training was part of the annual training programme, with most staff being up-to-date. The manager was able to clearly describe to us how they dealt with safeguarding issues and give us examples of concerns they had discussed with the local authority safeguarding team to determine whether further action was necessary to keep people safe.

Staff had a good understanding of the Mental Capacity Act 2005 (MCA) and how they ensured decisions made on behalf of people were made in their best interest. Staff told us they would consult with management, relatives or involve independent advocates if they were unsure if someone had capacity to make a decision. We saw MCA training was on the annual training programme and most staff were up-to-date with the training. This indicated staff had been given training to enable them to protect people who may not have capacity to make decisions for themselves.

The manager told us that there were no Deprivation of Liberty Safeguards (DoLS) orders in place. We did not observe any restrictions of people's liberty during the inspection.

Staff and management told us there were regular instances of challenging behaviour on the unit for people living with dementia. Staff had a good understanding of the behaviour which people presented, and how to calm them down. We saw staff dealt with an instance of challenging behaviour in an appropriate manner. The staff member was very patient and exerted a calming influence on the person, de-escalating the situation before any harm was caused. Staff told us they did not use physical restraint in the home.

We looked at care records and found risk assessments were in place where specific risks to people's safety were identified. For example, a risk assessment for smoking was in place to safely support a person to smoke outside. Risk assessments contained detailed control measures which indicated the service had assessed the risk in order to keep people safe, but not restricted them from doing activities.

The provider had an incident management system in place which ensured incidents and accidents were brought to the attention of the management to keep people safe. Incidents we found in people's daily care records had all been reported on the provider's incident forms. Each incident contained a lessons learnt form completed by the manager to ensure that the organisation improved following incidents to reduce the likelihood of a re-occurrence.

Are services effective?

(for example, treatment is effective)

Our findings

People told us that they were able to voice their preferences for example, in the gender of the people who assisted them and this had been respected. People told us they had choice in the time they liked to get up, for example one person told us they liked to get up at 6am and they were able to and have breakfast at this time. Relatives also confirmed to us that people were able to "lie in" as per their preferences.

We reviewed five people's care records. Care plans contained personalised information on how people preferred their care to be delivered , for example their preferred washing routine. It was clear people's specific needs and choices had been obtained in the completion of these plans. Care plans contained information on people's life history, likes and dislikes, which allowed staff to understand the people they were caring for and ensure care was delivered to their preference. The recording of this information was particularly important for those on the unit for people living with dementia who may not have been able to describe their likes, dislikes and personal preferences as easily.

Staff understood the individual needs, choices and preferences of the people we asked them about such as where they liked to spend their time and what activities they liked to be involved in. Staff told us they usually worked on one specific unit within the home which allowed them to develop relationships with the people they cared for, ensure continuity of care and allow them to maintain a greater level of understanding of people's needs. We observed care and saw staff gave people choices and asked about their preferences for example in asking if they had enough to eat, if they had enjoyed it and where they wanted to go next.

Mechanisms to discuss people's views and preferences about their longer term health and quality of life outcomes were in place through the monthly care plan reviews which involved people or their relatives. We saw evidence these were in place and people's views recorded with people or their relative's happy with the effectiveness of care at the home.

Care plans showed the service had assessed people's needs. These included mobility, nutrition, pressure area care, medication, personal care and emotional and wellbeing. Plans provided staff with clear instruction on how to deliver appropriate care that met people's needs as well as focusing on areas where people were able to be more independent. Although most people's care needs were assessed, there were no pain assessments in place. Pain assessments provide information to staff on how to identify if people are in pain and are especially important for people living with dementia that may not been able to communicate when they are in pain.

A range of mandatory training was available for staff to ensure they had the skills and knowledge to meet people's needs. These included training in a range of areas such as infection control, mental capacity, and dementia. This training gave staff the skills required to care for people effectively. Completion of mandatory training was good, although a number of staff were overdue updates in some areas which meant they may not have the latest skills and knowledge in those areas. We saw evidence on the service improvement plan there were plans to increase staff skill and knowledge further through specialist training such as nutrition, and dysphagia.

We asked the care manager about end of life care at the home. They told us that nobody was currently receiving end of life care in the home, although they were able to tell us about the preparations they had made for one person who was expected to require end of life care shortly such as ordering medication to ensure they received comfortable end of life care. All care plans contained an end of life wishes section which allowed people's end of life needs and choices to be recorded. Completion of these care plans was mixed with some blank or missing information with no explanation as to why these had not been completed. This meant that there was no evidence that all people had been asked for their end of life preferences and wishes.

The manager confirmed to us that most staff had not yet received end of life care training but we saw evidence that staff were booked on courses which would take place in April, May and June 2014. This would ensure staff had the skills to ensure they knew how to manage end of life care appropriately.

We asked the manager how they ensured they provided effective dementia care on the unit for people living with dementia. They told us they had access to a dementia specialist who was to visit the home shortly to discuss how dementia care could be improved. All staff had undertaken dementia training. The manager told us and the service

Are services effective?

(for example, treatment is effective)

improvement plan confirmed to us that ensuring a better range of activities and resources on the unit for people living with dementia to provide more effective care was a key priority.

We looked at how people's needs were met by the adaption, design and decoration of the home. The home was split over two units which both had various communal areas where people could choose to spend time. Communal areas were spacious and comfortable and the unit for people living with dementia practiced a higher level of security to keep the resident safe. People had appropriately sized rooms which comfortably contained their equipment and furniture. There was evidence people had personalised their rooms with their own pictures, ornaments and equipment.

The manager told us the unit for people living with dementia had been recently redecorated on direction of head office. The manager said that people who used the service had not been involved in the re-decoration of the area, for example in choosing colours but specialist dementia expertise had been obtained into the colour schemes. Some features were in place which supported people with dementia such as reduced use of patterned décor and distinctively painted bathroom doors. However the environment was plain and lacked character. There was nothing creative about the decoration to meet the needs of people living with a dementia. For example, there were no names or pictures on people's doors so people could identify their own rooms. There was no information personalised to the people using the service in the corridors for example photographs of memories which were important to them. Signage could also have been improved. Staff and the manager were not aware of any best practice guidance concerning the care of people with dementia for example around environmental design. Decoration in the main unit of the home was clean throughout however there was a lack of visible stimulation or personalisation and signage could have been improved for example names/pictures on people's doors.

We also found that the two baths in the unit for people living with dementia were currently out of order due to maintenance issues which meant people had to get a shower or make the trip over to the main unit in order to get a bath. Staff said that people rarely were taken over to the main unit and that if the baths in the unit for people living with dementia were repaired they suspected more people would take baths. Staff told us the baths had not been working for several months. This indicated that at present people were not always given a suitable choice due to the lack of working facilities.

Are services caring?

Our findings

The most recent resident survey results undertaken in 2013 showed that 100% of people were happy with the care and support they received at the home and 83% of people were happy with the kindness, dignity and respect showed by staff. The feedback obtained from people who used the service and their relatives on the day of the inspection was overwhelmingly positive regarding the caring nature of the staff, with people saying they were looked after well, by kind and patient staff. For example one person told us "staff are lovely" and other person said "I'd say it was first class really."

We observed care for seven hours in the communal areas of the home. Staff were kind and caring at all times and we observed some good interactions. For example, we saw a member of staff weighing people in the conservatory. They were caring and cheerful and displayed an appropriate mix of providing physical support and encouraging independence. Privacy of the results was maintained. Our use of the Short Observational Framework for Inspection (SOFI) tool found most interactions between staff and people were positive with no negative interactions. Staff smiled and used an appropriate mixture of verbal and non-verbal communication techniques to ensure people were comfortable and relaxed When staff were busy they explained to people that they would be with them in a minute.

People had access to privacy should they need it. Bedrooms were lockable and we saw evidence staff respected people's privacy for example in knocking on bedroom doors before entering. Where staff were discussing confidential or private matters with people, we saw they displayed awareness of who could be listening and took people to the side to ensure conversations remained confidential. This indicated people's right to privacy was respected by staff.

A health professional who regularly visited the home told us staff were caring and supportive and that they would have no problem recommending the home to a relative. They said care practices in the home were good and staff all had caring and respectful attitudes.

Staff told us people were well cared for and they thought their colleagues were kind and compassionate and that the home was really good at employing staff with the right attributes to ensure respectful and dignified care. The main concern raised by staff was with regards to delivering appropriate care was that due to staffing numbers they were sometimes unable to give enough time to engage meaningfully with people, for example in prolonged conversations about people's past lives.

Staff had a good understanding of how to ensure people's dignity was respected, for example covering when hoisting and they understood the importance of ensuring people were treated with respect and given time to respond. Staff told us they had all received training in the delivery of care to people living with a dementia and told us that this was useful in understanding how to ensure people living with dementia were treated equally and in a dignified manner.

Staff had a good awareness of ensuring people's individual needs such as spiritual and religious were met. We saw evidence that the service arranged for people to see vicars and priests to meet these needs. Information was also present in care plans to inform staff of people's religious needs and staff were able to confidently describe how these needs were met.

There were dignity and dementia champions in place. These members of staff were responsible for promoting dignity and dementia, ensuring care practices in these areas were good and challenging any poor practice. This helped to ensure people received appropriate support in these areas of care.

Although the manager told us nobody was currently receiving End of Life Care, they told us that when needed, they would liaise with healthcare professionals to ensure expertise and the best end of life care was provided. In one person's records, who staff said would require end of life care in the future, we saw evidence the service had begun to co-ordinate care with the involvement of other health professionals. Their advice was clearly recorded so staff were provided with clear information on how to ensure appropriate care was to be given.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Through observations of care practice and reviewing people's care records it was clear that people were asked for their views and involved in decisions about their care and support. We saw staff asked people questions and patiently waited for a response in order for their views to be expressed. This included asking people where they wanted to go and what they wanted to do after lunchtime.

Each care plan contained a communication assessment which detailed how to ensure people were able to make decisions and voice their opinion with regards to the care. The assessment included whether they had capacity to make everyday decisions and the support they required in order to make these choices and preferences known. Care plans contained details of arrangements in place to support and protect people such as where lasting power of attorneys or deputies were appointed. Information on advocacy services was on display, detailing how people could access advocacy services to act on their behalf. The manager and staff had a good understanding of how to ensure decisions made for people with limited capacity were in their best interests, such as involving advocates, relatives and health professionals.

People's daily care records also showed us people were offered choices such as whether they wanted a shower and there was evidence choices had been respected, including refusals for example with personal care.

We saw evidence people or their relatives were involved in their care plan review. Care plans showed regular reviews had taken place, which detailed the resident/relatives opinions in relation to the care provided. Views on care had been clearly recorded, and we saw evidence that changes had been made, for example around laundry processes following clothing getting lost. A relative confirmed they had been involved in care plan review. One person who used the service also told us they had been involved in care plan review although another person was unsure. Relatives told us they were invited to general meetings on a six monthly basis and that the issues they had raised were acted on and they had received feedback on what had been done. They told us they always felt welcome by staff and management at the home.

The manager told us that care plans were reviewed by staff monthly. We saw evidence care plans were regularly reviewed. A range of care plans were in place which provided staff with information on how to meet people's individual needs. For example, information on how to ensure people's nutritional and personal hygiene needs were met. However in one person's care plan whose records showed they had been in discussion with their GP about their mental health needs, we found their emotional and psychological assessment had not been completed, the lack of information meant that staff may not provide personalised emotional care to meet their needs.

People's weights were regularly recorded as specified in their care plans. We saw evidence the service had been responsive to people's needs for example in ensuring dietary supplements were available following weight loss. There was evidence care plans had been updated with new information so staff could continue to meet people's needs for example one person had got a mattress for pressure area care and the details of this had been added to the care plan.

Food and fluid charts and nightly checks were in place for some people who used the service, demonstrating that the service was monitoring people's food and fluid input if they were at risk and undertaking nightly checks to ensure their needs were met. However, fluid charts were not always tallied and there were some gaps on food charts which meant it was not always clear whether people had been offered food and drink.

A health professional who regularly visited the home told us that they thought the service was responsive to people's needs and that staff were pro-active for example in identifying pressure area damage and referring appropriately. They told us staff followed their advice and provided good quality care.

Systems were in place to ensure people were not socially isolated. Each care record contained a plan which described how to ensure people were not isolated, maintained relationships and were involved in a range of activities. The home employed activities co-ordinators; we spoke with one of them who told us they involved people in a range of activities including sensory activities for those with dementia, book days and coffee mornings. The activities co-ordinators told us many activities were spontaneous and not on the rota. However many people who used the service told us there were insufficient

Are services responsive to people's needs?

(for example, to feedback?)

activities, for example one person said "they don't organise a lot" and another said "There are not many activities organised". We looked at the activities rota and found there were many days without any planned activities.

We saw evidence of good community involvement for example priests and vicars visited the home. We spoke with one community visitor who confirmed that their visits were regular and gave us examples of activities they had organised with people such as carol singing at Christmas.

Staff did not always have the time to spend with people although all basic care tasks were carried out. For example, on observing care in the unit for people living with dementia we saw some people were left for up to an hour without any interaction with staff and were left to sleep, venture into a withdrawn state or be left to talk to themselves. We also saw one person's buzzer was ringing for 15 minutes before staff came to assistance. Two members of staff on the unit told us that they due to staffing constrains they didn't always have enough time to spend time with people. This showed us that there were insufficient staff to ensure people were provided with appropriate stimulation, companionship and activity.

We saw evidence people's complaints and concerns were responded to appropriately. People told us they felt comfortable raising concerns. For example one person said "I speak to the manager if anything bothers me." Informal concerns were logged as well as formal written complaints. We saw these were responded to appropriately and the manager was able to tell us of action they had taken following receipt of these complaints. Minor concerns were also recorded in the care plan review. The complaints procedure was clearly displayed within the home and a complaints policy was in place which detailed how the organisation responded to complaints. Compliments were also recorded, which recorded people's positive views and let the service know in areas where it was exceeding expectations.

Are services well-led?

Our findings

The home had a registered manager in post and we found all required notifications had been reported to the Care Quality Commission.

We found limited systems were currently in place to determine safe staffing levels. The manager told us that staffing was based on a 1:6 ratio on the unit for people living with dementia and a 1:8 ratio on the residential unit. However there was no documentation which assessed how they had come to this conclusion. The home was not currently using a tool to determine safe staffing levels and as such the layout, dependency, level of behaviour that challenges or number of incidents was not used as a factor for describing safe staffing levels. These were all factors that staff said contributed to the stretched staff resources. This was a consistent area where staff and people who used the service felt the home required improvement. The use of a formal tool may assist in addressing these concerns.

People who used the service and relatives spoke positively about the effectiveness of management. For example, relatives told us that any issues raised were acted on and that feedback was given to them on the changes made. People told us they felt comfortable raising concerns and that they could approach the manager.

Staff said they felt supported by the management at the home and were able to raise concerns openly. Staff said the manager listened to their concerns and would resolve them where they had the power to do so. Staff were open with us and able to discuss with us areas of good practice and areas where improvements were required.

The provider had a set of values which were well understood by staff and management based on honesty, respect, accountability and reliability. Staff told us they were provided with information on these values at induction, and on various corporate training courses. Appraisal documentation linked people's objectives to these values and performance against these values was assessed. This helped to promote a positive and consistent culture within the service.

We saw evidence that regular staff meetings were held which included general staff meetings, care meetings and team leader meetings. There was evidence that staffs' views had been recorded in detail, for example concerns over staffing levels. There was evidence management were aware of these concerns and had gone some way to addressing them. For example, the manager told us that action was being taken to increase the number of staff on the bank, this was confirmed by the service improvement plan which would reduce the likelihood of the service falling short of the target staffing levels. The manager said that although they had identified having more staff on a day to day basis would be beneficial to people who used the service, this would be more of a challenge due to budget constraints outside of their control.

Where staff had written to the provider with concerns, again these had been fully investigated and staff had been provided with a written response to the concerns. This indicated that the provider valued staff and listened to their comments and concerns to ensure the service improved.

There was a general consistency between what staff and management said were the key challenges to the service. Staff and management both acknowledged that maintaining target staffing levels was a challenge and that staff were often stretched. They acknowledged that this had affected staff morale and the manager told us increasing staff morale was one of the key objectives of the home. During the inspection the management team were very open with us about what worked well at the service and where further improvement could be made.

People who used the service were involved in the running of the service, through periodic resident meetings. We looked at the latest meeting from November 2013 and saw arrangements for mealtimes, laundry, activities care and management were discussed. There was evidence people's views were recorded and the manager was able to give us examples of changes they had made to the way the service was run following people's comments.

The manager told us at present people were not involved in the recruitment of staff but this was something that the provider was looking into for the future to further involve people in the running of the service.

Systems and processes were in place which ensured that concerns and complaints were used as an opportunity to learn. The manager completed a lessons learnt investigation following each incident to ensure that improvements were made. We saw investigations in safeguarding, and staff conduct had been completed and fully investigated. This indicated the home reflected on

Are services well-led?

incidents to ensure continual improvement. The details of all incidents and complaints was logged each month, so that the regional manager could review the incidents that had occurred and ensure that relevant learning had taken place and to monitor the level and type of incidents/ complaints received to look for any trends.

We saw evidence the regional manager visited the home regularly, to review audits conducted by the home manager and complete their own audit. We saw evidence action plans were produced as a result of these visits and the manager was able to show us how they were working towards completing them. This indicated to us the home had systems in place to continually improve the experience for people who used the service.

The provider had a service improvement plan in place dated April 2014 which detailed the improvements required to the home to ensure it continually improved. We saw that progress on the actions was regularly updated. For example, with regards to staffing the April 2014 update stated that two new members of staff had started, but the home were waiting for another three staff to start employment.

Emergency plans were in place which included a business continuity plan so that care would continue to be provided should a disaster or emergency occur.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There were not sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.