X9 Healthcare Castle Bank Limited

Castle Bank Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 21 and 22 February 2017 and was unannounced. This meant the provider or staff did not know about our inspection visit.

The service was last inspected on 3 March 2016, at which time the service was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the inspection of 3 March 2016 we identified the following breaches:

Regulation 9 (person centred care)
Regulation 12 (safe care and treatment)
Regulation 13 (safeguarding service users from abuse and improper treatment)
Regulation 17 (good governance)
Regulation 18 (staffing)

During our inspection of 3 March 2016 we found care plans were disorganised and did not reflect person centred care. Person centred care means ensuring people's interests, needs and choices are central to all aspects of care. At this inspection we found care files had been reviewed and improved, were easy to follow and did contain person-centred information. The service was therefore no longer in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection of 3 March 2016 we found the provider failed to retest the water supply for legionella in a suitable timeframe following professional advice. We also found personalised emergency evacuation plans (PEEPs) were out of date, there was no emergency 'grab bag' in place, the scales used to weigh people had not been calibrated and the temperature of the medicines room had regularly exceeded safe levels. We found during this inspection all these concerns had been addressed. This meant the service was no longer in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection of 3 March 2016 we found staff knowledge regarding mental capacity required improvement and the management of Deprivation of Liberty Safeguards (DoLS) was disorganised. We found during this inspection that improvements had been made in both regards and the service was no longer in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection of 3 March 2016 we found there were insufficient auditing and quality assurance processes in place. We found during this inspection a range of auditing processes had been implemented and maintained to good effect. This meant the service was no longer in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection of 3 March 2016 we found there was insufficient staffing to adequately support people who used the service at lunchtime. At this inspection we found there were sufficient staff to support people

at lunchtime, and throughout the day. The service was therefore no longer in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Castle Bank Residential Home is a care home in Tow Law, County Durham, providing accommodation and personal care for up to 28 older people, including people living with dementia. There were 20 people using the service at the time of our inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like directors, 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.

All areas of the building including people's rooms, bathrooms and communal areas were clean, with infection control risks well managed and appropriately resourced, for example with the support of an infection control champion.

The storage, administration and disposal of medicines was generally found to be safe and in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE). 'When required' medicines were supported by specific plans, whilst where people needed topical medicines (creams) we saw body maps were used to ensure staff applied them correctly. Controlled drugs were safely stored and regularly audited.

Risks to people were managed through risk assessments and associated care plans. These risks were reviewed regularly and included advice from healthcare professionals to keep people safe.

Staff displayed a good knowledge of safeguarding principles and the potential signs of abuse. They were clear what to do should they have any concerns and expressed confidence in concerns being taken seriously by management. People we spoke with, their relatives and healthcare professionals consistently told us the service maintained people's safety.

There were effective pre-employment checks of staff in place, including Disclosure and Barring Service checks, references and identity checks.

Visiting professionals had confidence in staff, giving examples of where staff had sought advice to ensure people's healthcare needs were met.

Staff completed a range of training, such as safeguarding, health and safety, moving and handling, dementia awareness, infection control, dignity and respect and first aid. A number of staff were completing NVQ Levels 2-5 and confirmed they received good levels of support and encouragement. The system the registered manager used to remind staff to refresh their training needed review, and the registered manager agreed to do this.

Staff had built positive, friendly relationships with the people they cared for and people told us they knew staff well. Staff were supported through regular supervision and appraisal processes.

We saw people had choices at each meal as well as being offered alternatives if they preferred. People spoke positively about the food on offer. We observed staff supporting people to eat and drink in a friendly, attendant manner and the dining experience was pleasant.

The premises benefitted from some aspects of dementia-friendly design, such as signage and contrasting coloured doors, although we found the ongoing refurbishment works had yet to consider people's individual needs. The refurbishment plans we saw did not incorporate dementia-friendly design and this was something the registered manger committed to reviewing.

Care planning documentation was well organised and sufficiently detailed, whilst staff displayed a good knowledge of people's needs, likes and dislikes.

Whilst improvements had been made to the standard of person centred care planning, we found there were still improvements to be made, particularly with regard to the environment and activities. The registered manager agreed to review these areas and ensure that people's individualities and personal histories were considered when planning the environment and activities.

Group activities were planned by an activities coordinator and people told us they enjoyed these activities.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The registered manager displayed a good understanding of capacity and we found related assessments had been properly completed and the provider had followed the requirements in the DoLS.

The atmosphere at the home was welcoming. People who used the service, relatives and external stakeholders agreed.

The service had good community links and the registered manager and administration officer were able to explain how they planned to make new community links to the benefit of people who used the service.

Staff, people who used the service, relatives and external professionals we spoke with knew the registered manager and were positive about their accessibility, knowledge and accountability.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Improvements had been made to the storage of medicines, whilst other aspects of medicines management, such as 'when required' medicines, were in line with current best practice.

Improvements had been made to emergency planning to ensure people who used the service would be safe in the event of an emergency.

There were sufficient staff on duty to safely meet the needs of people who used the service.

Pre-employment checks of staff reduced the risk of unsuitable people working with vulnerable adults.

Is the service effective?

Good

The service was effective.

A range of training was in place, whilst staff were supported through supervisions, appraisals, and the opportunity to complete vocational courses.

The premises had undergone some refurbishment and more was planned. The registered manager agreed to ensure further refurbishment would incorporate dementia-friendly design.

People's nutritional and hydration needs were consistently met and people enjoyed their mealtime experiences, with choices at each meal.

Is the service caring?

Good

The service was caring.

People who used the service, relatives and external stakeholders agreed that staff were patient, compassionate, and had formed meaningful bonds with people who used the service.

People were supported to make their own choices and to

maintain their independence when completing day to day tasks, whilst people consistently told us their dignity was respected and upheld.

Care plans were written with the involvement of people who used the service and their relatives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The service had improved the levels of person centred information readily available in care files but had yet to fully incorporate this information into person centred environmental changes or activities.

Staff liaised promptly with external healthcare professionals and incorporated their advice into care planning to ensure people's changing healthcare needs were met.

The complaints process was readily available and people who used the service and their relatives confirmed staff and management responded to their queries, and that they would complain, should they need to.

Is the service well-led?

Good

The service was well-led.

Quality assurance and auditing work had improved since our last inspection. It was systematic and generally effective in addressing any inconsistencies and making improvements to the premises and care planning.

People who used the service, relatives and staff were complimentary about the hands-on approach of the registered manager.

The service had built and maintained good community links with a local church and community centre to ensure people who used the service, and staff who supported them, were not isolated.

Castle Bank Residential Home

Detailed findings

Background to this inspection

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

We visited the service on 21 and 22 February 2017 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector and one expert by experience. An expert by experience is a person who has relevant experience of this type of care service. The expert in this case had experience in caring for older people and people living with dementia.

We spent time speaking with people who used the service and observing people and staff in the communal areas of the home. We spoke with seven people who used the service and two relatives. We spoke with nine members of staff: the registered manager, the administration officer, four care staff, the handyman, the domestic assistant and the cook. Following the inspection we spoke with two health care professionals and one external trainer/assessor.

During the inspection visit we looked at four people's care plans, risk assessments, four staff training and recruitment files, a selection of the home's policies and procedures, meeting minutes, maintenance records, surveys and quality assurance documentation.

Before our inspection we reviewed all the information we held about the service, including previous inspection reports and the action plan sent to CQC by the registered provider. We also examined notifications received by the CQC. A notification is information about important events which the service is required to send to the Commission by law. We spoke with professionals in local authority commissioning teams, safeguarding teams, the local infection control team and Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

Good

Is the service safe?

Our findings

At the previous CQC inspection on 3 March 2016 we identified concerns that legionella testing had not been undertaken in line with professional advice received. At this inspection we found testing for water borne viruses had occurred regularly and that control measures were in place to minimise the risk of the recurrence of such viruses, such as the regular flushing of little used water outlets. We saw other checks and servicing of the premises were in place to help keep people safe. Portable appliance testing (PAT) had been recently completed, whilst testing of the fire alarms and emergency lighting was in progress on our arrival. We saw that fire drills happened regularly. We saw equipment such as the lift, hoists and other lifting equipment had been serviced by external contractors and a gas safe engineer had inspected the boiler. People were therefore no longer at risk through the lack of adequate testing of facilities. Likewise, the scales used to monitor people's weights had been calibrated recently, meaning they could be relied upon to give accurate readings.

We found emergency planning to be good, with a business continuity plan in place and improvements made to Personalised Emergency Evacuation Plans (PEEPs) and the procurement of an emergency 'grab bag.' This contained a current copy of the PEEPs, a torch, writing equipment and emergency blankets. This had been another area CQC had raised concerns about during the last inspection and we found the registered manager had taken steps to ensure the service was better prepared in the event of an emergency.

At the previous CQC inspection we also highlighted concerns regarding the storage and administration of medicines. We found the room in which medicines were stored regularly exceeded safe limits. At this inspection we found the registered manager had tried a number of ways to resolve this problem, firstly by boxing in water pipes, then installing an extractor fan and lastly by installing an air conditioning unit. We found this to be in operation during our inspection and the temperature in the room had not exceeded 25 degrees in the recordings we saw. This meant the registered manager had taken action to address an area where the service had previously not complied with the regulations.

We looked at other aspects of medicines administration and found them to be safe. For example, controlled drugs were kept securely, in a separately locked cabinet within the medicines wall cabinet. Controlled drugs are medicines that are at risk of misuse. Weekly audits had been undertaken by the registered manager and we saw stock levels recorded in the book corresponded with the amounts remaining.

We saw Medication Administration Records (MARs) contained people's photographs, allergy information and details regarding each medicine. For example, where a medicine was prescribed to be taken 'when required', this was supported by a specific set of instructions to help staff identify when this might be required and what impact they should expect it to have. Likewise, topical medicines (creams) were managed safely through the use of body maps so that staff knew where to apply the creams correctly. We saw staff competency with regard to medicines was reviewed by the registered manager annually.

People who used the service and their relatives told us they felt protected from harm. One person told us, "Staff are always looking after me," whilst another said, "They make me safe by catering for me – they gave

me a walking frame." Another person told us, "Staff are pretty quick at responding if I press the buzzer." One relative told us, "Absolutely, 100%." They went on to tell us how their relative had a persistent problem with recurring bed sores and that they attributed the fact these had now healed and no longer recurred to the diligence of staff.

We reviewed this person's care documentation and found there had been regular contact with district nurses, detailed notes kept and evidence of care provided in line with advice from those nurses in order to help the person recover and minimise risks.

External professionals we spoke with consistently told us they had no concerns with the standards of care at Castle Bank, or the ability of staff to keep people safe. One said, "I've never had problems or concerns, none. I've always found there has been plenty of staff around and they always interact appropriately."

They went on to say, "It's always clean," and we found the home to be clean and free from odours, including bedrooms, communal areas, the laundry and kitchen. One person told us, "My room is always immaculate," whilst another said, "They're always cleaning and the toilets are kept spotless." We spoke with one of two domestic assistants, who had a clear routine in place to give each bedroom a monthly deep clean as well as maintaining communal areas. When we spoke with the local infection control team they similarly raised no concerns about the service. This demonstrated people were protected from the risk of acquired infections.

There were sufficient staff on duty to meet the needs of people who used the service. People who used the service and their relatives, along with external professionals, stated they felt there were sufficient staff to meet people's needs, as did staff. We observed call bells being responded to promptly, and staff assisting people in a calm, patient fashion throughout the two days of our inspection, with no evidence of people not having their needs met. One relative said, "Sometimes carers are a bit stretched if people need help at the same time," but qualified this by stating they had not observed anyone ever being put at risk.

We spoke with the handyman, who was responsible for the general maintenance of the premises. They had a systematic approach and other members of staff used a maintenance file to log any concerns about the fabric of the building. The handyman told us they received all necessary equipment from the registered provider and we found the building to be generally in a good state of repair. We spoke with one person who used the service who said, "There was water dripping from my bedroom ceiling and they didn't panic. They got there as quick as a flash and gave me a different room." This meant people were not placed at risk through poor maintenance and upkeep of systems within the service.

We saw risks were managed and mitigated through an initial assessment then ongoing review, with the involvement of healthcare professionals where necessary. We saw advice had been sought from external professionals where the risks people faced changed or increased, and that care plans had been updated to ensure staff knew how to mitigate the risks people faced.

Staff we spoke with had been trained in safeguarding and displayed a practical understanding of their safeguarding responsibilities. They described potential sources of risks, types of abuse and what they would do should they have concerns, including whistleblowing (directly telling someone outside the organisation) if needed.

We saw incidents and accidents were systematically recorded and acted on. The registered manager reviewed these incidents to identify any common patterns or trends.

We reviewed a range of staff records and saw that in all of them pre-employment checks including enhanced

Disclosure and Barring Service (DBS) checks had been made. DBS refresher dates were also documented and adhered to. The DBS maintains records of people's criminal record and whether they are restricted from working with vulnerable groups. We also saw the registered manager had asked for at least two references and ensured proof of identity was provided by prospective employees' prior to employment. This meant that the service had in place a consistent approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

Good

Is the service effective?

Our findings

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the previous CQC inspection of 3 March 2016 we found staff knowledge regarding mental capacity required improvement and the management of the DoLS was disorganised. We found during this inspection that improvements had been made in both regards. For example, no DoLS applications had expired and the registered manager tracked them with a planner to ensure they were reviewed when necessary. We saw there had been regular contact by the registered manager with the local authority DoLS team to ensure they were working within guidelines and to ensure appropriate documentation had been submitted to the local authority. The registered manager and staff we spoke with demonstrated a good understanding of mental capacity issues, including DoLS.

We found people who used the service received effective care from staff who had the relevant knowledge and skills. New staff underwent an induction process and, where they were new to care, the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. The registered manager told us they also planned to use modules from the Care Certificate to refresh and enhance current staff knowledge. Mandatory training included fire safety, first aid, safeguarding, dementia awareness, infection control, MCA and medicines administration. The majority of training was via e-learning although more in-depth face-to-face courses with a practical aspect had also been provided, such as falls awareness and moving and handling training.

We found training needs were monitored by way of a file which documented what training staff had received and when they were due to refresh this training. We found this had generally worked, although two members of staff had yet to refresh some training. The registered manager had highlighted the need for staff to update their training on the noticeboard, then written to staff individually who had yet to refresh their training. The registered manager agreed this system inevitably meant there could be delays between identifying when a staff member needed to refresh training and them actually completing it and committed to reviewing the system in place.

Staff we spoke with confirmed they were also supported to complete additional qualifications such as an NVQ in Health and Social Care. The external assessor we spoke with told us, "[Registered manager] is always ringing – they make sure staff have time off the floor to complete the work." This demonstrated the registered manager had ensured people's needs were met through the provision of relevant training and

vocational support.

We saw regular staff supervision and appraisal meetings had taken place. A supervision is a discussion between a member of staff and their manager to identify strengths and areas to improve. Appraisals are an annual review of staff performance. Staff we spoke with stated these conversations were open and they were supported to raise concerns and discuss future development.

People who used the service, relatives and external professionals were complimentary about the level of staff knowledge and experience. One relative told us, "I think they are trained properly – they are so gentle with [person] and know what they're doing." When we spoke with visiting professionals they expressed confidence in the knowledge of staff and how they helped them to do their jobs. One said, "Castle Bank staff are the ones that listen most and they're always able to give me a good background. It works both ways. They helped me get the Emergency Health Care Plans (EHCPs) in place to help try and keep people out of hospital and looked after how they wanted to be." An EHCP makes communication easier in the event of a healthcare emergency. We reviewed a sample of EHCPs and found them to be detailed, setting out the emergency care needs for each person, relevant to each of their specific illnesses, such as diabetes or dementia, and how they wanted to be treated in the event of a relevant health emergency. This demonstrated staff worked well with external professionals to ensure people's needs were met.

We reviewed two Do No Attempt Cardiopulmonary Respiration (DNACPR) forms. A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. We found them to be current and sufficiently detailed, including evidence of the decision being discussed with people's relatives where they lacked the capacity to make such a decision.

We saw other examples of advice from health and social care professionals incorporated into people's care, for example from GPs. We saw people were supported to access primary health care, such as GP visits and dentist appointments, along with secondary health care such as chiropody.

With regard to nutrition we found the cook and other staff to have a good knowledge of people's favoured foods, their dislikes, and whether they were on a specialised diet, such as a soft diet.

We saw people were regularly weighed and staff used the Malnutrition Universal Screening Tool (MUST). MUST is a screening tool using people's weight and height to identify those at risk of malnutrition. We cross-referenced the MUST file with individual care files and found the records were accurate and contemporaneous, as was the list of people requiring specialised diets in the kitchen. One healthcare professional told us, "Their knowledge of fortified foods is really good, and they're real sticklers for Focus." We saw staff had recently been visited by the Focus on Undernutrition team. Focus on Undernutrition is nationally recognised system of ensuring people at risk of malnutrition are identified and supported through fortified diets.

At the last inspection of 3 March 2016 we observed a person who used the service at lunchtime not being adequately supported to choose alternative options. During this inspection we observed one person who didn't like the cheese sandwich they had chosen. They were offered a range of alternatives, eventually choosing salmon. People who used the service told us they enjoyed the food and had a range of choices at each meal. One person said, "It's good food and you get a choice – sometimes there is too much!", whilst another said, "You can't fault it and if you don't like it they ask you if you want something else." We found lunchtime to be calm and relaxed, with sufficient staff who helped people attentively.

We observed people being offered drinks and snacks throughout the day via a tea trolley. One visiting nurse

we spoke with said, "They have a beautiful tea trolley – really appetising and really varied."

We saw the registered provider had made some alterations to the premises to meet the needs of people, such as signage, the conversion of an old bedroom into an additional lounge space and the conversion of another old bedroom into a salon for hairdressing. We also noted bedroom doors contrasted with wall colourings. We found however more could be done to ensure the environment was dementia friendly. For example, the main corridor on the ground floor was painted a dark yellow colour, with a hand rail that did not significantly contrast, whilst the lightshades were all in frosted glass. This meant the corridor was noticeably darker than some other areas of the home, which benefited from natural light. All staff we spoke with agreed this corridor required improvement. The corridor could therefore presented a risk of falls to people with impaired sight. We saw there was a refurbishment plan in place but it did not address dementia-specific considerations such as the type of lighting, flooring or paint choices. The registered manager committed to reviewing the Department of Health document, 'Dementia-friendly Health and Social Care Environments' before a refurbishment planning meeting they had with the registered provider the following week.

Good

Is the service caring?

Our findings

People who used the service and their relatives were consistent in their descriptions of kind, caring and respectful staff. One person who used the service said, "They treat me rightly, as I would expect to be," whilst another said, "They always listen to me and are kind and considerate." Another stated, "They are all honest and there's not one bad carer." Relatives we spoke with expressed similar opinions, telling us, for example, that, "It's a nice, homely, friendly atmosphere, people are happy and staff care about their work."

There was a strong consensus that staff treated people as individuals and supported them to maintain their independence. One person who used the service told us, "I choose my own clothes, I dress myself – I'm in charge," whilst another said, "I make my own bed, choose my own clothes and get myself dressed. They help as much as I need but I'm fine at the minute."

Throughout the two days of the inspection we observed staff taking time to interact with people in a personable, patient manner, using eye contact and gentle physical contact where appropriate.

One person who used the service told us, "Yes, there are times when they can sit and chat and times when they have to be serious and get on with work," whilst another said, "They're always chatting when helping me." Care plans reflected the importance of chatting to people who used the service whilst supporting them and we found this happened in practice. This meant staff built a rapport with people who used the service, and vice versa.

We saw staff giving people a range of options and waiting for them to choose. This focus on choice was evident in the interactions we observed. Care planning documentation went into a good level of detail about people's abilities and limitations and how to support them to remain independent with regard to day-to-day tasks.

We observed people being treated in a dignified way and when we spoke with people who used the service and their relatives they confirmed staff respected their dignity. One person who used the service said, "They always ask you to make sure you're satisfied with what they're doing and they keep doors shut when bathing or seeing to personal hygiene." A relative said, "They make sure people are informed and chatted to all the time and shut doors when they should." There was a poster displayed prominently in the entrance hall regarding how to promote dignity and we found staff had consistently done this. The registered manager told us they were looking to introduce a dignity champion to ensure standards of respect and dignity were maintained.

We saw staff engaging in humorous interactions with people who used the service where appropriate and this was in part due to the continuity of care the service could provide through having a low turnover of staff. Some staff had been at the service for over ten years. One staff member said, "It's small, it's settled and you get to know the people you're caring for." Another said, "They are all grans and granddads to me." People we spoke with behaved in a calm, trusting way with staff. This demonstrated staff had developed meaningful relationships with people who used the service.

We reviewed recently returned surveys, which presented further evidence of the caring attitudes of staff. One response read, "The standard of care is very high – everyone is treated with respect and their dignity maintained."

With regard to advocacy we saw the registered manager had written to people's relatives to make them aware of an independent advocacy service, should they wish to use it. We also saw relatives were involved in key decisions about people's care when people lacked capacity to do so, meaning people were represented by those who knew them well.

External professionals we spoke with referred to the welcoming atmosphere at the home and the fact they had witnessed warm and friendly interactions between staff and people who used the service. One said, "There are lots of people living with dementia and staff have never got frustrated or behaved in a way that wasn't appropriate – they understand people's needs and quirks and go with them." Another said, "There is always a warm welcome. We know most of the staff and it seems the residents do too – they have a stable group." This evidence again demonstrated the positive impact of the continuity of care the service was able to provide.

We saw that people's beliefs were respected and upheld, with people who used the service able to attend the adjoining Catholic church or the Church of England church in the village, whilst one person received regular visits from a vicar.

People's rooms were homely and well personalised, with ornaments, photographs and decorations and people who used the service took pride in their rooms.

We saw people's personal sensitive information was securely stored in locked cabinets, whilst people's consent was sought for the sharing of their personal information with, for example, healthcare professionals.

Requires Improvement

Is the service responsive?

Our findings

At the previous CQC inspection of 3 March 2016 we found care files to be in a confused and disorganised state. During this inspection we saw the registered manager had, as per their action plan, renewed all care files and ensured they were ordered via an index, accessible and up to date.

We also identified concerns about the lack of person centred care evident in care files during our inspection of 3 March 2016. Person centred care means ensuring people's interests, needs and choices are central to all aspects of care. During this inspection we found the registered manager had regularly reviewed and audited care plans to ensure they were written from a person-centred perspective. We saw improvements had been made. For example, in one person's care plan there were specific details about how staff should support the person, not merely in terms of completing a task but how they should speak and interact with the person during the task to ensure they were involved and free from anxiety. Another care plan stated, "I get a little upset if I can't have my hair done by the hairdresser," and, under the 'what makes me feel better?' section, "A cup of tea and a chat with someone who knows me well." We found staff understood the importance of people's individual preferences.

Likewise, we saw in each file we reviewed that a 'This is Me' document had been completed. 'This is Me' is a tool produced by the Alzheimer's Society which lets health and social care professionals know more about people's needs, interests, preferences, likes and dislikes. We found care files contained a good level of person-centred information and, when we spoke with staff, they demonstrated a good knowledge of this information.

We found the registered manager still needed to make improvements with regard to how person centred information could be continually sought and used to improve the activities people participated in and their environment.

For example, we saw residents/relatives meetings had been advertised by the registered manager but attendance had been extremely low, with only one resident and one relative at the last meeting in December. This meant an opportunity to gather the views of people who used the service and their relatives about their preferences was being missed. We saw one of the weekly planned activities was a 'group chat and tea' and the registered manager agreed this could be a more informal means of ensuring a group discussion took place to capture the likes and dislikes of people who used the service, and their relatives, on an ongoing basis.

The registered manager stated there were plans to improve the garden area but had not considered the possibility of incorporating people's personal histories into the planning of that space. For instance, we noted a number of people who used the service had a background in, and a love of, farming. This information was available to the registered manager and registered provider but had not as yet been incorporated into their planning of the outdoor space, for example through planning a vegetable patch or applying a 'farm' theme. The registered manager agreed to review people's individual likes, dislikes and personal histories before revamping the garden area.

Similarly, whilst some aspects of the building had been updated we found there was as yet no focus on individual needs or preferences in the planning. For example, there was a board with a set of door knockers in the corner of one corridor. We did not see anyone who used the service interacting with this and it was placed out of the way of the main corridor. Similarly, we saw a number of rooms with pictures on the outside, whilst some had none. We asked the registered manager if they had considered memory boxes or other means of orientation for people who used the service. They told us they had raised this at residents/relatives meetings but that uptake had not been good.

We also saw the activities co-ordinator had put in place an activities plan for each person who used the service, although we found some of the objectives in these plans were limited and generic. We fed this back to the registered manager, who agreed to review the plans and ensure they were cross-referenced against the 'This is Me' documents on file and other known information to ensure the activity plans were more person-centred.

This demonstrated that the service had yet to establish the model of person-centred care the service's literature aspired to. We spoke with the registered manager about this issue and they committed to ensuring the planning of communal spaces and activities would consider people's individual likes, dislikes and personal histories.

The activities co-ordinator was absent from work during our inspection but the majority of people who used the service and relatives we spoke with confirmed they knew who they were and gave examples of the kinds of activities that had taken place. These included skittles, armchair exercises, an exercise session with an external provider, making hats at Easter, Christmas decorations and, more recently, gingerbread biscuits for a Valentine's tea party and zoo lab. Zoo lab is a touring company who take a range of interesting creatures into services. We also saw there had been visits by a local choir, other singing entertainers and a visit by local schoolchildren. During our inspection we observed people taking part in a game of skittles facilitated by care staff and all enjoyed the session.

We saw the activities co-ordinator had a weekly activity planner in place and that this incorporated one-to-one time with people to ensure those who did not partake in group activities had dedicated time. One person told us, "The coordinator talks to you and asks your opinion, which is good."

We found evidence that some of people's individual preferences, likes and dislikes were taken account of. For example, one person liked to have a doll with them as they found it calming. We saw this was noted in their care plan and staff were aware of its importance. Another person had previously enjoyed knitting and we saw, whilst they were no longer able to knit, the service had a number of 'twiddle mitts', which had been made and donated by an ex-employee. Twiddle mitts are knitted hand muffs with interesting textures and items attached inside and out. They are designed to provide simple stimulation to people living with dementia, whilst promoting increased flexibility and brain stimulation.

We saw a monthly newsletter informed people who used the service about upcoming events and birthdays, as well as local events, such as a spring fair at the community centre, at which the service would have a stall.

We saw care plans were reviewed regularly and the majority of people and relatives we spoke with confirmed they were involved in the review process.

We saw surveys were used as a means of routinely gathering more information from relatives, people who used the service and their relatives. We saw recent responses were positive regarding the standard of care, staff and facilities and that the registered manager had reviewed these responses to try and identify and

potential patterns in the feedback.

We saw people's health needs were responded to promptly and there was ongoing involvement with a range of healthcare professionals, such as GPs and visiting nurses. Professionals we spoke with were complimentary about the levels of responsiveness displayed by staff. One healthcare professional told us, "They recognise when things aren't quite right and they ask for advice," whilst another said, "They have always been good at recognising changes in behaviour and what that could mean – they alert us if that happens." We also saw emergency health care plans were in place detailing people's medical, mobility and communicative needs to better inform healthcare professionals, should a person need to receive emergency treatment outside the home. This demonstrated that staff had a good understanding of people's healthcare needs, and when to seek additional advice or support to meet those needs.

With regard to complaints, we saw information regarding how to make a complaint was clearly displayed in communal areas and in the service user guide. People we spoke with and their relatives knew how to make a complaint and who to approach. One person told us, "Yes, straight to staff or management," whilst another said, "I'd go straight to the manager, but I have no complaints." We saw there had been no recent complaints.

Good

Is the service well-led?

Our findings

The service had a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the CQC to manage the service. The registered manager had relevant experience in health and social care and a good knowledge of people's needs, likes and dislikes, as well as the day-to-day workings of the service.

We found they had made a range of improvements to the service since the last inspection, particularly with regard to ensuring people were cared for in a safe environment, person centred care documentation, the accuracy and accessibility of care records and medicines storage. We found the registered manager had adhered to the action plan they had sent CQC in order to make the necessary improvements and achieve compliance with the regulations.

At the previous inspection on 3 March 2016 we raised concerns about the lack of systems in place to monitor, assess and improve the quality of care provided. One particular concern was that visual checks may have been happening, but the results of these checks were not formally documented. During this inspection we saw the registered manager had introduced a range of audits. They had an auditing file which included the results of regular audits of the kitchen facilities and catering, infection control, health and safety, medication, laundry, care plans and training.

We reviewed these audits and found they had made a demonstrable impact on the accuracy and completeness of records. For example, recent audits had identified that, respectively, one care plan had not been reviewed in line with the scheduled date, whilst another lacked specific details in one care plan. In this case the registered manager ensured staff updated the care plan with more specific instructions regarding how to support the person when mobilising. Other audits we saw identified, for example, a faulty boiler and a broken kitchen appliance. We saw these were noted and corrective action put in place, with the audits signed off when the repairs had been made. This meant regular, documented auditing had been introduced and had been shown to have a direct impact on the quality of the person centred care people who used the service received.

We also saw the nominated individual completed a monthly visit to the service and documented their findings, such as discussions with people who used the service, staff, the standard of cleanliness, décor and equipment. The action plan at the end of each monthly visit set out what the nominated individual felt needed to be in place to improve the service, for example, further refurbishment. As discussed in the Responsive section, we found the plans regarding refurbishment had not as yet considered the specific impacts of environmental changes to people living with dementia. The registered manager agreed to research this fully and incorporate into refurbishment planning.

We observed people who used the service interacting comfortably with the registered manager and they displayed a good awareness of people's needs. People we spoke with and their relatives confirmed they knew the registered manager and felt they and other staff were friendly. One person told us, "They are pretty good. I get on well with them all. [Registered manager] is very nice and seems a good boss," whilst another,

when asked about the best thing about the service, told us, "It's very open – everyone's up front and honest."

Members of staff we spoke with told us they had confidence in the registered manager and that the culture was one in which they could raise queries or concerns openly. This was supported by the conversations we had with people who used the service, their relatives and through our observations.

External professionals we spoke with all confirmed they had positive working relationships with the registered manager and staff more generally. One told us, "[Registered manager's] attitude is very much, 'can we do more?' They chase up any queries and they value staff having the time and knowledge to get things done."

With regard to establishing aspects of best practice, we found the registered manager had some awareness of the work of the University of Stirling with regard to dementia-friendly care, although they acknowledged they needed to improve the breadth and depth of their understanding and ensure this was incorporated into care and environmental design planning.

The registered manager had introduced an infection control champion, who attended external meetings and fed back to the team. We asked the registered manager if they planned to have similar champions for, for example, dementia and dignity. They told us they would consider this.

We saw the registered manager had more generally formed strong community links, for example with the church and the community centre. This ensured that people who used the service remained a part of the community they lived in. We also saw the administrative officer had brought an additional level of enthusiasm regarding partnership working to the role and that they had already used this to make enquiries with other potential local partners. The registered manager had recently attended a provider's forum, whereby care home owners and managers meet and share instances of best practice or concern. There service had a deputy manager although they were absent at the time of the inspection. We found the appointment of the administration assistant had given the registered manager time to ensure they managed other aspects of the service. We saw the registered manager and the administrator were due to attend the next meeting shortly after our inspection. This meant the registered manager had taken steps to ensure they delegated work appropriately but also sought feedback and advice from outside the service to protect against the risk of the home becoming isolated.

During the inspection we asked for a variety of documents to be made accessible to us, including policy documentation and care records. The latter were all accurate and in line with the registered manager's plans to make care records more orderly. We found some policies contained outdated references to local authority contact details and the CQC. The registered manager told us they were in the process of reviewing policies and that these errors would be rectified.