Caliburn (Care Homes) Ltd

Evergreen Residential Home

Inspection report

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Date of inspection visit: 27 January 2015
Date of publication: 16/07/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 27 January 2015 and was unannounced. Evergreen is registered to care for up to 17 older people with needs related to dementia. There is a passenger lift to assist people to the upper floors and the home is located close to a park area and transport links.

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

Risks to people were assessed and acted upon though there was not always sufficient emphasis on how to maximise freedom.

Staff were trained in safeguarding and understood how to recognise and report any abuse.

Summary of findings

Staffing levels were sufficient to care for people safely; however, staff deployment was not always suitable to provide quality care. Staff were suitably recruited to protect people.

Medicines were safely handled so that people could be assured they received their medicines as prescribed..

The registered manager, provider and staff were clear about their responsibilities around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). DoLS assessments had been carried out for people and decisions made in people's Best Interests were recorded with appropriate multidisciplinary involvement. However, people who required a mental capacity assessment did not have one recorded, which meant it was not clear how people's capacity to make decisions was supported or promoted. You can see what action we told the provider to take at the back of the full version of the report.

The environment was unsuitable for people with a dementia. The signage, carpet patterning and lighting was not appropriate to assist people living with dementia with orientation.

Staff received suitable induction and training for their role, with specialist training where necessary, for example in caring for people living with dementia. They received regular supervision which supported them to develop professionally and to support the people they cared for.

The registered manager consulted with health care professionals to ensure people received the benefit of specialist advice and support.

People had their needs related to nutrition and hydration assessed and plans were in place to ensure these were met. We observed that people did not have a choice at the lunch time meal, even though the menu stated there was a choice. The meal on the day of inspection did not appear very appetising and people did not appear to enjoy it.

People were not always attended to with regard for their privacy and dignity. Some staff were kind and thoughtful, others did not engage with people in a caring or compassionate way. Staff varied in their knowledge of people's preferences and what was important to them, so that people were not assured of always receiving a kind and compassionate service.

Care was not always planned so that it was centred on the person. Activities were not based on individual needs and people did not receive care which helped them to retain skills or which stimulated memory.

The service had a complaint policy but there was no evidence of any complaints or concerns, or any consideration of how people's suggestions on how the service could be improved may have been taken into account.

The service had a system for assessing and monitoring the quality of care; however, this was sometimes informal and there was insufficient analysis of findings to ensure that plans could be drawn up to improve care.

The registered manager often demonstrated effective care of people with a dementia, however, they did not always communicate the culture, values and ethos of the throughout the staff team to ensure people received a consistent quality of service. The registered manager did not sufficiently consult with people, those who acted on their behalf, staff or health care professionals to ensure the service continually improved for the benefit of people living at the home.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was safe. People told us that they felt comfortable. However, staff were not always deployed to ensure people's safety was protected.

People were in a safe environment though the lighting was unsuitable in places.

People were protected by clean communal areas; however, some other areas of the home were not clean and posed a risk to infection control.

People were protected by staff who were safely recruited.

People were sure they received the right medicines, and these were handled safely.

Staff had received safeguarding training and understood how to act if they suspected abuse.

Is the service effective?

Requires improvement

The service was sometimes effective.

Staff were trained and supported to meet people's needs.

People had access to healthcare services when they needed them.

The acting manager and provider were aware of the principles of the Mental Capacity Act 2005 and how to make an application to request authorisation for a person's deprivation of liberty. However, people had not received mental capacity assessments when needed.

The environment had insufficient signage to assist people to orientate around the home and the carpets in places were patterned in a way which can cause disorientation in a person with dementia.

People were not sufficiently consulted about their meals however their nutritional needs were met and they had access to food and drink.

Is the service caring?

Requires improvement

The service was sometimes caring.

Some staff had positive relationships with people and were reassuring and kind in their approach. However, some staff did not care for people in a compassionate way.

People were not involved in decisions about their care as much as they could be.

People told us that they were treated with respect and regard for their privacy and dignity. We found however that some care practice did not respect privacy or dignity.

Summary of findings

Is the service responsive?

Requires improvement

The service was not responsive to people's needs.

Care plans contained guidance on how to meet health needs however they did not include sufficient information on people's individual social or spiritual needs and were not personalised.

There was insufficient evidence that care had been discussed and planned with people. People's needs were usually met but their preferences were not sufficiently understood.

People did not have sufficient stimulation or interest in their lives.

There was insufficient evidence that the registered manager used people's concerns and complaints to improve the service.

Is the service well-led?

Requires improvement

The service was not well led.

The registered manager was experienced and skilled in caring for people with a dementia .However; the manager had not always communicated the culture, values and ethos of the home to all staff clearly.

The quality assurance system was incomplete. There were gaps in checks and safeguards in the home which placed people at risk of harm and there was little emphasis on improvement.

People were not sufficiently consulted or surveyed for their views.

Staff understood their roles and responsibilities.

Staff meetings were not used to discuss and consult with staff on how to improve the service.

The registered manager had made statutory notifications to the Care Quality Commission where appropriate.

Evergreen 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.

This inspection took place on 27 January 2015 and was unannounced. It was carried out by one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information.

We did not request a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

On the day of the inspection we spoke with two people who lived at the home, the provider, the registered manager, and five members of staff including cleaning staff. We noted written comments from three visitors. After the inspection we spoke with two health and social care professionals about the service.

We spent time observing the interaction between people who lived at the home and staff. We also carried out a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing

care to help us understand the experience of people who could not talk with us.

We looked at some areas of the home, including some bedrooms (with people's permission where this was possible) and communal areas. We also spent time looking at records, which included the care records for eleven people. We looked at the recruitment, supervision and appraisal records of three members of staff, a full staff training matrix, rotas for the past two months, five care plans with associated documentation, a number of audits and policies and procedures.

Requires improvement

Is the service safe?

Our findings

The service was safe. People told us that they felt comfortable in the service. They did not tell us they felt unsafe.

Staff had a good understanding of safeguarding adults, could identify types of abuse and knew what to do if they suspected or witnessed anything they considered abuse. Staff told us they had received safeguarding training and training records confirmed this.

The service had policies and procedures for safeguarding vulnerable adults which were available and accessible to all members of staff. Care workers told us they would refer any concerns to a senior member of staff and knew that they would also need to contact North Yorkshire County Council which is the lead for the safeguarding of vulnerable adults in the area. This meant staff had the necessary knowledge and information to make sure people were protected from abuse.

We saw written evidence that the manager had notified the local authority and CQC of safeguarding incidents where necessary and had cooperated in investigations.

We looked at four care plans and saw individual risk assessments had been carried out for each person. The risk assessments we saw included behaviour which may challenge others and required areas of personal care. Risk assessments included instructions for staff on how minimise risk and guidelines on how to ensure people did not have their liberty unnecessarily restricted. Staff told us they understood how to protect people through following the risk assessments and were clear for example on how to approach people who may be distressed or agitated to calm them and protect them and those around them. This meant people were protected against the risk of harm.

The environment was safe, though it was not particularly suited to the needs of people with a dementia, being on several floors. We noted a number of potential hazards, for example early in the day the internal lining of the lift was partly torn creating ragged plastic edges. This was a potential risk for people. However, this was fixed by the end of the visit. The lower ground floor lounge had poor levels of natural light supplemented by ceiling lights that created pools of light and shadow. This could cause people to miss their step. The home had a resident pet dog which was a dark colour and could cause a tripping hazard. We spoke with the registered manager about some of these hazards. They told us that they had assessed the risks around the pet dog and had concluded that the benefit to the people who lived at the home outweighed the risk. We noted that people did enjoy having the dog in the home and saw that people responded well to it.

Standards of cleanliness in the Home were variable. The reception area and lounges were clean and smelled fresh. Most bedrooms were cleaned during the day of inspection though we noted that some sheets had reached the end of their useful life and needed to be replaced. Some carpets in the home were unclean despite having been vacuumed. Some bed linen was dirty and we found a soiled toilet, which was not cleaned despite our raising this with the manager and nearby staff. Hand towels in several en suite bathrooms, toilets and communal bathrooms were missing as was soap. Several en suite and bathroom waste bin lids were missing with waste material clearly visible. The flooring in one bathroom was still dirty after the cleaner had finished their cleaning. When these concerns were brought to the attention of the registered manager they acknowledged that these should have been addressed. The home had an infection control policy and procedure which staff had access to. We asked two members of staff about infection control and they understood what good infection control practice was. They referred to the use of aprons, gloves and the importance of hand washing when giving personal care to people. We saw records of training in infection control. Staff had received this training and those who were due to have updates had training planned.

The registered manager had arranged the accommodation for one person so that both they and other people who lived at the home were protected from harm. An alarm was fitted to this person's room so that if the door opened an alarm sounded and staff could attend to make sure this person and others who may be nearby were safe.

We examined staffing rotas and spoke with the registered manager about staffing levels. There were three care workers on duty each morning with two carers on duty each afternoon every day of the week. Care workers were usually deployed with consideration of their experience and level of skill, however, we noted that two staff who were relatively new in post were on duty together on the day of inspection. The registered manager told us this was because they had experienced difficulty recruited new staff and that the rota had been adapted because a member of

Requires improvement

Is the service safe?

staff was off work sick. The registered manager and ancillary staff were in addition to the care staff hours. When the manager was not available there was an on call system so that staff had back up when they required this. Through our observations and discussions we found there were enough suitably experienced and qualified staff to meet the care needs of the people living in the home. However, cleaning staff sometimes had to share their time between this home and Green Park, the sister home nearby. This meant that there were times when the staffing rota for cleaning staff was not correct and less staffing hours than on rota were devoted to keeping the home clean and hygienic.

Staff application forms recorded the applicant's employment history, the names of two employment referees and any relevant training. We saw that a Disclosure and Barring Service (DBS) check had been obtained prior to commencing work at the home and that employment references had also been received. This provided evidence that only people considered to be suitable to work with vulnerable people had been employed.

The home had a policy on whistle blowing. Staff told us that they understood the whistle blowing procedure and were confident to raise any whistle blowing concerns.

We looked at the arrangements in place for the administration, storage, ordering and disposal of medicines and found these were safe. Medicines were stored securely in a trolley in a locked medication room. We checked the medicines for three people and found the number of medicines stored tallied with the number recorded on the Medication Administration Records (MAR). Medicines which were not in the Boots monitored dosage system and were kept in packets were dated on opening and a running total was recorded. This ensured that staff would know when medicines became out of date and needed to be re-ordered. Creams were for individual's use, were dated on opening and recorded on a separate administration record. We checked blood sugar test records for three people and found these were recorded appropriately. Each MAR chart had a photograph of the person so that errors of administration were minimised. There were suitable storage arrangements for controlled drugs. A register was kept as required, and this was signed and checked by two members of staff at the time controlled drugs were given. Medicines which required refrigeration were stored in a designated fridge and staff recorded the temperature of this daily. Staff training records showed that staff had received up to date medicines training. A list of all staff who had training and were authorised to administer medicines was kept in the medicines store. This ensured that medicines were administered by suitably trained staff.

We recommend that the registered manager consults best practice advice on the maintenance of a clean and hygienic environment.

We recommend that the registered manager considers skill mix and experience more thoroughly when organising rotas.

Requires improvement

Is the service effective?

Our findings

The service was sometimes effective.

There was no information on most care plans about people's capacity to make decisions including which decisions they may be capable of making, at what time or what support they may require to make such decisions. Their consent to care and support was not recorded, either through signatures or through a record of discussion held with them or those who supported them. The home specialises in the care of people with dementia related illnesses and a good understanding of each person's mental capacity is central to ensuring effective care. This did not ensure that people were protected or that their involvement in decisions was promoted.

This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs related to dementia were not met by the way in which the environment was arranged, decorated or organised. There was no evidence that people were involved in decisions about the environment.

The home specialised in caring for people with a dementia, and areas of the home were protected by key pad. However, the décor of the building did not lend itself to effective dementia care. There was little signage to assist people with a dementia to orientate around the home. For example, toilets did not have a picture of a toilet on the door and people's bedroom doors were not all labelled with their name or a picture they might find familiar. The carpets were patterned in a way which research has shown can disorientate people with a dementia related illness. The registered manager had not acted on published best practice advice on creating an environment which promoted the well-being of people with a dementia. This meant that the environment did not support people's needs in relation to dementia.

The failure to provide a suitable environment to meet the needs of people with a dementia related illness is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt well cared for. One person we spoke with told us, "I love it here; I wouldn't want to be anywhere else. I have lovely baths." Another person told us, "They help me with washing my hair. My clothes are always clean. I've just had my nails clipped too. The staff (encourage) me to help out in the kitchen." One relative had written "The improvement in my mum is amazing."

We looked at staff induction and training records. Induction followed Skills for Care topics and there was an additional induction specific to the home, its values and philosophy of care. ('Skills for Care' is the strategic body for workforce development in adult social care in England). Staff told us that they had received induction before they began their mandatory training. During this time they developed a good understanding of each individual's care needs and the philosophy of the home. Staff were knowledgeable about the needs of the people they supported and knew how people's needs should be met.

Staff told us that new employees usually spent time shadowing a more experienced member of staff before they were permitted to work alone. This was to make sure they understood people's individual needs and how risks were managed. We noted a skilled and experienced senior member of staff. However, we also saw that one new member of staff was on duty with an inexperienced member of staff. This meant that on the day of inspection, people did not benefit overall from a staff team that was sufficiently experienced or skilled.

In addition to mandatory training, staff received specially sourced training in areas of care that were specific to the needs of people at the home. For example, a number of staff had received training in dementia care and specialist advice on palliative care.

Staff told us that they received regular supervision and appraisals and we saw evidence of this in the staff records we reviewed. Staff told us this supported them to develop professionally and gave them support to give the care people needed.

The home had links with specialists, for example in diabetic care, nutrition, community psychiatric nurse support, pressure care, continence care and the speech and

Is the service effective?

language therapy team (SALT). This helped them to offer appropriate and individualised care. We saw that referrals for specialist input had been made where required and their involvement was recorded. A care worker told us that they closely liaised with a range of health professionals including opticians and podiatrists. They were aware of when they needed to refer to these professionals and the limit and scope of their own role in relation to health care. A health and social care professional told us that the service successfully cared for a number of people with complex care needs and that they managed behaviour which may challenge in an effective way.

The registered manager told us they had links with local GPs and district nurses and we saw that their visits and advice were recorded for each individual. Staff told us that they were given information about any changes to care plans following health care professional visits at hand over. We saw records of referrals to specialists and staff told us that people were accompanied to appointments so that they could record important information about people's care needs.

Care plans showed those people who were assessed at risk of malnutrition or dehydration and there were clear instructions on how to manage the risk to protect people. Those people who needed specialist diets had these in place. For example one person had begun to lose weight, however, the dietician had been consulted, and nutritional supplements had been introduced which had reversed the weight loss trend. Since this intervention advice from the dietician and diabetic nurse had been incorporated as necessary into the care plan. Reviews and decisions made about nutritional care were clearly recorded. People's food likes and dislikes were recorded along with any allergies to ensure people received the kinds of food that were safe for them and that the service had information about foods they enjoyed.

People appeared to respond well to some staff interventions. We noted one member of care staff who was skilled at working with those who were agitated or verbally aggressive, talking with them to find out what the underlying concerns may be. Other staff communication was not so effective. For example, we saw one care worker sitting for periods of time in a lounge without interacting with people at all. One member of staff was able to describe the medical conditions of a number of people we identified and understood the needs arising from these.

We made observation at meal times and throughout the day. People were frequently asked between meals whether they would like a drink and a snack.

People were seated at their tables waiting for lunch for thirty five minutes before the meal arrived. This was too long for people and meant that the meal time did not begin with a good experience.

A menu was available and appeared to be on a three week rotating cycle. Menus gave varied choice of nutritious food with specialist diets such as pureed meals included. However, people were not offered the choice of meals on the menu for that day.

That day's lunch menu indicated the main course was a choice of fish pie or sausages. The fish dish looked unappetising and seemed to be mostly mashed potato and the accompanying vegetable were not as described on the menu. The dessert was not as written on the menu either. Most people did not each much of this lunch. Nobody had the sausages and we discovered this was because this option was not actually available. It was unclear whether the options on the menu had been shared with the people who lived at the home and it appeared that people were given a plate of food without having the options explained.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that any decisions are made in people's best interests. The registered manager told us that a small number of applications had been made to the local authority for deprivation of liberty safeguards to be put in place, but that nobody had yet been assessed as being deprived of their liberty.

When we looked at training records. Staff had received detailed up to date training on DoLS and the MCA. Care staff were clear on the process for DoLS and mental capacity assessments as well as best interests decision making and the implications of lasting power of attorney powers. This meant they had the training to understand how to involve people in decisions about their care. However, we found that records did not show that people were involved in decisions about their lives.

Staff did not routinely ask for people's consent before they offered care, however, we did observe that staff often described what was happening so that people understood

Requires improvement

Is the service effective?

how staff were assisting them. When people declined support, staff were respectful and returned to try again later if necessary. Care plans described how to observe body language or facial expressions to judge whether people were giving consent to care.

We recommend that the registered manager consults best practice advice to ensure that sufficiently skilled and experienced staff are on duty at all times.

We recommend that the registered manager provides people with a choice of appealing foods they enjoy and assist people so that this is a pleasant experience for them.

Requires improvement

Is the service caring?

Our findings

The service was sometimes caring.

While on a tour of the building the Registered manager once walked into a person's room without knocking finding that the person was unexpectedly inside the room. On one occasion the Registered manager opened a toilet door while the person was using the toilet. This did not respect the person's dignity or privacy. They were not particularly apologetic about this and it appeared this was a regular occurrence rather than an isolated incident.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people who required protective clothing at meal times to preserve their dignity were not offered this and consequently there were a number people who spilled food on their clothes which did not protect their dignity.

People told us that they were attended to in a caring way. One relative had written "I know there was nowhere (my loved one) would rather have been than at Evergreen. She thought of you as a friend and indeed as extended family."

Another relative had written "Your timely phone call gave us enough time to make the long journey to say goodbye. We are also grateful for the times you visited her at the hospital." The registered manager told us that they and staff would make a point of visiting people in hospital so that they saw a friendly face they may recognise.

We observed the registered manager speaking with people in a kind and caring manner, taking time to understand what they may need and what may be troubling them. Another member of staff spoke with people in a kind and caring way. They were skilled at interpreting behaviour and pacing interactions so that the person smiled and looked at ease. This member of staff made a point of including people who were either withdrawn or agitated and responded kindly to all.

However, at lunchtime two members of staff were assisting people with their meal. This was done in a mechanistic manner without any particular warmth and minimal interaction with either person. For some of the time a member of staff looked away from the person they were assisting and did not interact, encourage or adjust their pace to meet the person's needs.

Throughout the day of inspection the communal areas were often quiet without any friendly chatter going on. We observed one member of staff who spoke quietly and quickly so that the person did not have the chance to understand or respond to what was being said.

One member of staff told us that they understood people's personal histories, their likes and dislikes. We observed that one senior member of staff in particular did appear to know people's preferences and social relationships well. However, there was insufficient evidence of personal histories on file, and little was recorded about what was important to people, likes, dislikes or preferences. This meant that there was insufficient information to ensure all staff could offer person centred care or to have meaningful conversations with people about their lives.

We observed that staff did not always ask people for their views on their care or their preferences. When the meal was served, people were given a plate of food rather than being asked what they would like and people were not consulted about activities.

Care reviews did not always include details of consultation with people or those who acted on their behalf. However Best Interests decision documentation did sometimes record people's views about their care.

We recommend that the registered manager seeks best practice advice on ensuring people are cared for in a kind and caring way at all times.

Requires improvement

Is the service responsive?

Our findings

The service was not responsive to people's needs.

Evergreen is a home which specialises in caring for people with a dementia, however, the manager had not consulted best practice advice or acted on this to provide care which promoted wellbeing in people with a dementia. For example, in the communal areas of the home there were no objects of interest, or rummage boxes to stimulate people's curiosity. There was no evidence of memory work with people, the use of visual prompts, pictures, newspapers or magazines to stimulate conversation. This meant that the care offered was not focused on individual needs.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the staff assisted them to do the things they chose. One person told us, "Sometimes I go for a walk with a carer just down the road and use my own money to buy things." Another person told us, "Sometimes I can stay up late," which was something they clearly valued.

We spoke with health and social care professionals. One professional told us that the service did not record all the consultation they felt was made. They also told us, "the home has some good staff who understand the needs of people with a dementia but it also has some staff who do not understand this well. It means that sometimes staff listen and act on what they see and hear for people's benefit, sometimes they don't.".

There was some evidence that people's interests and individual histories and preferences were recorded, however, on four of the files we looked at this information was very brief. The plans did not focus in any detail on people's skills, goals or aspirations. There was little consideration of what may help to improve wellbeing. For example there was no document which introduced the person, their likes, dislikes, who and what was important to them, significant events in their personal history or starting points for conversation. (Such a document is often called 'This is me' a tool made available from the Alzheimer's society). Plans did not include evidence of consultation with the person in whichever way they were able to contribute, or with those acting on their behalf.

There was some detail on care plans about how to support people with their daily living skills, however, plans could include more detail on how to support people to retain independence.

There was little consideration of how to interpret what people were saying or how they were acting. There was insufficient guidance to staff on how to look beyond people's actions to support their emotional well-being. Some staff did not interact with people very much and spent time sitting by them in silence. We did note however, that one member of staff did engage in numerous positive interactions with people which they appeared to enjoy.

A limited range of activities were offered to people. This included dominoes, craft, drawing and going on short walks or visits to a cafe. The manager told us that they celebrated people's birthdays with a cake and special tea, that they played karaoke, listened to music or had a sing along. One care plan recorded, "cannot join in activities as unable to do so." This suggested that each person was fitted into an available menu of activities rather than having a personalised plan which focused on the person and tailored support to meet their individual needs. From our observations all activities appeared to be chosen by staff, not the people who lived at the home. We observed a game of dominoes. This session started by the staff member suggesting the activity without offering choice. Two people played dominoes with the member of staff for at least forty five minutes and during this time the member of staff was focused on the game and took their lead from the people who were playing. People appeared to enjoy this.

The Home played music to residents in the lower ground floor lounge throughout the day. It was music related particularly to the first world war. If the intention by the Home was to stimulate the memories of residents it was unlikely to do so as no one at the home was of an age to remember this war. Again there was no consultation about which music to play.

Care plans were regularly reviewed, and changes made to the existing plan where necessary.

Requires improvement

Is the service responsive?

The service had a complaint policy and procedure, however, there were no complaints recorded since the last inspection and no learning recorded arising from any discussion with people or those who acted on their behalf. There was no written evidence of any changes to care made as a result of consultation with people. Staff told us that problems were discussed in staff meetings and the manager told us that they continually asked visitors and people who lived at the home if there was anything they could do to improve. However, this was not recorded.

We recommend that the registered manager consults best practice advice on how to consult with people effectively to improve the service.

Requires improvement

Is the service well-led?

Our findings

The service was not well led.

Staff told us that people and those who acted on their behalf were sometimes surveyed for their views on care. Although we saw some evidence of surveys, there was little written evidence available that this led to improvements in the service. The manager and provider told us that they collated comments from people and developed a plan of improvements which resulted from this informal consultation, However, when we looked at the plan of action it was very brief and of little practical use.

One member of staff told us that they felt supported by the manager, that the manager was fair but firm and that they quickly intervened if they felt staff were not caring for people appropriately.

The manager told us that they held regular staff meetings. We did not see a record of staff meetings; however staff confirmed these meetings took place. Staff told us meetings were to discuss problems and pass on information, they were not seen as an opportunity for staff to give their views or to discuss feedback about ways of improving the service. This meant that staff views did not consistently inform improvements to the service.

The manager and staff told us there were no resident or relatives meetings so that people could be informed about changes or consulted with about improvements. Any individual consultation with people was not regularly recorded so that it was difficult to assess how comments were used to improve the service.

The manager described their role as 'leading by example'. We observed that the manager was skilled at interacting with people who had a dementia related illness, and that they approached people with care and affection. They had a clear commitment to good quality interactions based on in depth understanding of each person's life history, interests and family. Unfortunately because such knowledge was not captured in care plans in adequate detail or communicated effectively to all staff, the resulting care was inconsistent. We observed both very good personalised care and interactions which lacked warmth or understanding. This meant that the vision of good care held by the manager was not consistently applied for people's benefit.

The provider supported the manager with regular visits to the home, however, systems for monitoring the service were not closely linked to actual care practice and there was a disconnect between the system which the provider preferred and what the manager actually did. The manager delegated responsibility for auditing to senior staff. When we spoke with staff it appeared that a senior member of staff audited the medicines every week and any errors were reported to the manager. We saw infection control audits with staff signatures to say these had been completed. However, the manager had not taken control of assuring the overall quality of the service was improved. For example, they were not aware of how the cleaning schedule was organised. The audits we saw emphasised the prevention of harm rather than improvement in quality. Therefore the service was not always managed in a way which displayed a clear commitment to values, ethos improving the experience of people living at the home.

The manager did not share the provider's enthusiasm for using the computer or for recording information on spread sheets. They did not have ownership of a quality assurance process which was meaningful to them and this meant that people did not benefit from an effective system.

Staff were clear about their individual roles and knew when to refer to more senior staff or the manager for advice as necessary to ensure people received the care they needed.

Notifications had been submitted to CQC as appropriate and the manager had demonstrated their involvement and cooperation in safeguarding investigations carried out by the local authority. Health and social care professionals told us that the manager worked with them to remedy shortfalls in the service.

We recommend that the registered manager develops a quality assurance system which is meaningful to them and uses this to demonstrate improvement to the quality of care for people who live at the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not provide suitable stimulation for people with a dementia related illness.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People or people who acted on their behalf were not involved in decisions about their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The environment was not suitable to meet the needs of people with a dementia related illness.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People's privacy and dignity were not protected.