The Check House Limited

The Check House

Inspection report

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Ratings

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

Overall summary

The inspection took place on 26 and 29 October 2015 and was unannounced. We last visited the service in December 2013 and found the service was compliant with the standards inspected and no breaches of regulations were found.

The Check House is registered to provide accommodation for 49 people who require personal care and nursing and specialises in the care of people living with dementia. 49 people lived at the service when we visited. Staff were deployed to work in teams across the three areas of home, known as Ruskin, Main, and Rosetti and there were shared communal areas on the ground floor.

The service had a registered manager. 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

Summary of findings

and associated Regulations about how the service is run. The service had a clinical lead nurse who provided nursing leadership and advice to the registered manager and monitored nursing practice.

Staff were trained and knew how to manage people whose behaviours challenged the service, although care plans on managing this lacked detailed instructions for staff. This lack of detail in care plans about how to manage this increased the risks for others and staff, particularly for staff less familiar with the person and how to manage these behaviours.

Staff identified people at risk of malnutrition and dehydration and had detailed care plans in place about how to support those people. However, their food and fluid records were not accurate or detailed enough about their nutrition and hydration, although we observed those people were supported to eat and drink regularly. By the second day of the inspection, the registered manager had taken action to make improvements.

People were supported to receive ongoing health care support. Staff were knowledgeable about people's care and treatment needs. People were seen regularly by their local GP, and had regular health appointments such as with the dentist, optician, and chiropodist. The local community mental health team supported staff with some people's mental health needs and gave us positive feedback about staff skills.

Staff were kind and compassionate towards people, they had warm and caring relationships with them. The service was organised around people's needs by staff who knew each person, about their life and what mattered to them. People's views were actively sought, listened to and acted on.

People and relatives felt safe at the home, and risks for people such as from falls and choking due to swallowing difficulties were well managed. People were supported to remain active, and be as independent as possible. Hand rails, and other specialist equipment were available to help residents move around the home independently.

The home had a physiotherapist that supported people to remain mobile by providing advice about equipment and exercise plans. Regular exercise and fitness classes were held.

People and relatives were consulted and involved in developing and reviewing care plans. Care records were regularly reviewed and updated as people's needs changed. Most people were assisted to maintain their interests and hobbies and to try new things, through a varied programme of activities. They were supported to access their local community regularly. However, for people who remained in their rooms through choice or for health reasons, there was less evidence of how they were supported with their interests and hobbies, or to interact with people and avoid isolation.

Repairs and maintenance of the building and equipment were regularly undertaken. A new boiler had recently been installed although we identified some rooms where the water in hand wash basins was slightly hotter than recommended by the health and safety executive. We discussed this with the provider and registered manager, who immediately risk assessed these areas to identify further steps to reduce risks. They arranged for thermostatically controlled valves to be fitted to those rooms.

The culture of the home was open and friendly. There was clear leadership from the registered manager, and staff had delegated roles and responsibilities. The provider had a range of quality monitoring systems in place which were used to continually review and improve the service. Where there were concerns or complaints, these were investigated and positive action taken. The provider participated in good practice initiatives such as Dignity in Care to encourage high standards of care and to keep staff up to date with practice. There was evidence of continuous improvements being made in response to feedback and the findings of audits.

We found one breach of regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

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?

Good 

The service was safe.

People and relatives felt safe at the home. People's risks were assessed and actions taken to reduce them as much as possible.

People were protected because staff understood signs of abuse and were confident concerns reported were investigated and dealt with.

People were supported by enough staff so they could receive care and support at a time convenient for them.

Accidents and incidents were reported and action was taken to reduce the risks of recurrence.

People received their medicines on time and in a safe way.

Is the service effective?

Requires improvement 

Some areas of the service were not fully effective.

Staff were trained to manage people whose behaviours challenged the service. However, care plans about how to manage this lacked detailed instructions for staff.

People were supported with nutrition and hydration, although improvements were needed in completing detailed food and fluid records.

People were supported by skilled and experienced staff, who had regular training and received support with practice through supervision and appraisals.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity, relatives and health and social care professionals were consulted and involved in decision making about people in their 'best interest'.

People were supported to maintain their health and access healthcare services. Staff recognised any deterioration in people's health, sought medical advice appropriately and followed it.

Is the service caring?

Good 

The service was caring.

Staff were kind and compassionate towards people, and had warm and caring relationships with them.

Staff supported and involved people to communicate and express their views and make their own decisions, which staff acted on.

Summary of findings

The service was organised around people's needs by staff who knew each person, about their life and what mattered to them.

Is the service responsive?

Good

The service was responsive.

Care was personalised, staff knew people well, and cared for them as individuals.

There was a varied programme of activities, which encouraged people to socialise and pursue their interests and hobbies, although this was less in evidence for people who remained in their rooms.

Changes in people's mood and their care needs were quickly recognised and promptly responded to.

The provider had a complaints process which was on display in the home. People and their relatives felt confident to raise concerns and were supported to do so. Complaints were investigated and appropriately responded to.

Is the service well-led?

Good

The service was well-led.

There was a registered manager and the culture was open, friendly and welcoming.

People, relatives and staff expressed confidence in the management and said the home was well organised and run.

People, relatives and staff views were sought and taken into account in how the service was run and suggestions for improvement were implemented.

The provider had a variety of systems in place to monitor the quality of care provided and made changes and improvements in response to findings.

The Check House

Detailed findings

Background to this inspection

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

The inspection took place on the 26 and 28 October 2015 and was unannounced. The inspection team comprised of three inspectors. We reviewed information about the service from the Provider Information Return (PIR), and other information we held about the service such as from notifications. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We met most of the people using the service, spoke with seven relatives and visitors and looked in detail at seven people's care records. Not everyone was able to verbally share with us their experiences of life at the home. This was because of their dementia/complex needs. We therefore used the 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 spoke with 20 staff, which included the provider, registered manager, nursing and care staff and a range of ancillary staff. We looked at six staff records, at training and quality monitoring records such as audits and survey findings. We sought feedback from health and social care professionals who regularly visited the home including GPs, therapists, nurses from the community, hospice and mental health services, and received a response from 10 of them.

Good

Is the service safe?

Our findings

People said they felt safe living at the home and felt confident to raise any concerns with the manager or other staff. One visitor said, “People are safe and secure.”

Staff had completed safeguarding training and were knowledgeable about signs of abuse and how to report concerns. Contact details about how to report concerns to the local authority safeguarding team were on display in the staff office. Staff felt confident any concerns they raised would be investigated and actions taken to keep people safe.

The registered manager had notified several safeguarding concerns to the local authority safeguarding team and to the Care Quality Commission since the last inspection. Most of these related to incidents where a person exhibited behaviours that challenged the service, such as physical and verbal aggression toward other people due to the effects of their dementia. The notifications showed the registered manager had taken additional steps in response to each incident to further reduce risks. For example, by involving the GP and referrals to the community mental health team to review people’s mental health needs. In communal areas we observed staff responded to changing circumstances and potential risks quickly and proactively. For example, by distracting one person from taking another person’s newspaper.

Staff were aware of whistle-blowing procedures, whereby they could report any concerns ‘in good faith’ without repercussions. Following an incident at another home within the group, the provider had recently reviewed their ‘Whistleblowing policy’. In addition to the existing arrangements, they had identified a whistleblowing champion in each home so staff had the options of raising concerns with a peer staff member in addition to the provider or manager. This meant staff had more options if they felt their concerns were not being listened or responded to appropriately

Each person had a detailed risk assessment and risks for people such as from falls or choking due to swallowing difficulties were well managed. In the provider information return (PIR) the provider highlighted the monthly accident audit enabled the service to identify and address causes to minimise falls. Where a person was identified at higher risk of falling, they were referred to the community 'falls' team for assessment to identify any additional steps staff could take to promote the person to remain active, whilst minimising their risks of slips, trips and falls. For example, by wearing good fitting footwear and through the use of mobility aids.

People were supported to continue to take part in the activities they enjoyed, despite some risks. For example, where people had reduced mobility or a high falls risk and had always been active and enjoyed walking, a member of staff accompanied them to walk in the garden or into town.

The provider used evidence based risk assessment tools to identify risks, such as the Braden Scale for predicting pressure sore pressure sore risks. Care plans identified steps staff needed to take to reduce individual risks for each person as much as possible.

Accidents were reported and showed each accident was reviewed to identify whether additional steps could be taken to reduce the risk of recurrence. The service had recently introduced incident reporting, which was providing valuable information about other areas of risk, especially for staff.

Medicines were safely managed to ensure people received them safely and on time. Staff who administered medicines were trained and assessed to make sure they had the required skills and knowledge. Where people had medicines prescribed, as needed, (known as PRN), some but not all had protocols in place about when they should be used. The clinical lead undertook to ensure these were in place for all. Where a person who lacked capacity was receiving their medicine covertly, (usually crushed or added to food or drink), there was evidence that this had been agreed with their GP in their ‘best interest’.

Medicine administration records (MAR) were well completed and were usually signed in by two staff, and there were no missed signatures. A policy for the use of homely remedies such as cough medicine and antacids was in place, which had been agreed with the local GP and community pharmacist. Where dosages of medicines varied for a person, depending on their blood results, there was a clear system in place to confirm the required dose with their GP. Where people needed clinical observations checked before their medicines were administered, (such as by checking their pulse), these were completed.

Medicines were audited regularly and action taken to follow up any discrepancies or gaps in documentation. All

medicines were securely stored and all stock entering and leaving the home were accounted for. Room temperatures and those of the medicines refrigerator were monitored to ensure medicines were stored at manufactures recommended temperatures. However, the refrigerator thermometer was not being reset after temperature checks, which the service agreed to address. The application of prescribed creams were recorded on a MAR chart with a body map, which identified where on the person they needed to be applied. However, these charts did not always document the frequency or reason for application. The registered manager undertook to work with the GP and community pharmacist to get these details added.

There were sufficient numbers of staff within the service to keep people safe and meet their needs. A dependency tool was used to identify required staffing levels based on people's individual needs. For example, where a person's mental health needs indicated they needed to go out several times a day to prevent them becoming restless and agitated; staff were deployed to support this. This helped keep the person safe and reduced the risk of aggression for other people and staff. Rotas were planned in advance and showed recommended staffing levels were maintained most of the time.

People and relatives said staff provided care at a time convenient for each person and responded promptly to call bells. The staffing levels allowed staff to spend time with each person chatting to them, offering assistance and reassurance. Some people who needed assistance to eat received help in an unhurried way.

Staff said there were enough staff on duty at all times to allow them to safely care for people. In addition to nursing and care staff, the home employed six activity co-ordinators, to support people with their interests, activities and hobbies. They also employed kitchen staff, cleaners, maintenance staff and a part time gardener. There were no nursing staff vacancies and the registered manager was advertising for one care staff vacancy, although they said recruiting staff was becoming more difficult. Existing staff worked additional hours to cover sickness and annual leave. This meant people had continuity of care from staff who knew them well and were familiar with their care needs.

All appropriate recruitment checks were completed to ensure fit and proper staff were employed. Staff had police and disclosure and barring checks (DBS), and checks of qualifications, identity and references were obtained. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. Checks were made to ensure nurses were registered with the Nursing and Midwifery Council.

Environmental risk assessments were undertaken for all areas of the home and showed measures taken to reduce risks for people. For example, one person was receiving oxygen, and there was clear signage to identify this in the main entrance and in the person's room to advise emergency services in case of a fire. All chemicals and detergents used in the home were risk assessed and securely stored.

When we visited on 26 October, we identified an increased risk of scalds in some people's rooms. This was because we found temperatures of hot taps in five rooms slightly exceeded the Health and Safety Executive (HSE) recommended temperatures. (No hotter than 44 °C should be discharged from outlets that may be accessible to vulnerable people). This had not been identified through temperature monitoring, although checks showed some hot water outlets were between 46 and 55 °C, higher than recommended. Although hot water warning signs were on display, some people did not have the cognitive ability to understand the risk. We discussed this with the registered manager, who reported no scalding incidents had occurred. However, they undertook immediate risk assessments and identified further steps to reduce risks. In addition, the provider arranged for work to be undertaken to fit thermostatically controlled valves to those rooms. This work was in progress when we visited on the second day and has since been completed. The provider also replaced all manual thermometers in shower and bath areas with digital thermometers. This was to ensure staff could more accurately check water temperatures before bathing people.

Individual fire risks assessments were in place and each person had a personal emergency evacuation plan showing what support they needed to evacuate the building in the event of a fire. A written contingency plan was in place in the event of a major emergency requiring evacuation of the home. Equipment was regularly serviced and tested as were gas, electrical and fire equipment. Weekly fire checks of the fire alarm system, fire extinguishers, smoke alarms, and fire exits were

Good

Is the service safe?

undertaken. A member of maintenance team said, "I want to see these people safe." Monthly checks were undertaken to make sure wheelchairs were safe for people and to check for trip hazards, electrical faults and make sure fire exits were clear. A member of the maintenance staff was due to undertake a three day health and safety course in November 2015 to obtain a recognised qualification.

There was an ongoing programme of repairs, maintenance and refurbishment to improve the environment of the home. For example, a new boiler had recently been fitted, and new furniture purchased for communal areas of the home. Flooring was replaced in the kitchen as recommended by a visit from the food standards agency, which has since visited and awarded a top rating of five.

People were cared for in a clean, hygienic environment and there were no unpleasant odours in the home. One relative said the home always smelled nice and that was an important factor in choosing the best home for their relative. Staff had access to hand washing facilities and used gloves and aprons appropriately. Cleaning schedules were maintained of daily, weekly, and monthly cleaning. Housekeeping staff had suitable cleaning materials and equipment. Soiled laundry was appropriately segregated and laundered separately at high temperatures in accordance with the Department of Health guidance.

Requires improvement

Is the service effective?

Our findings

Before each person came to live at the home, staff undertook a detailed assessment of their needs. Although the level of detail in care plans was generally good, there was a lack of detail in care plans about how to support people whose behaviours sometimes challenged the service. For example, one person needed staff assistance with all personal care and was frequently physically and verbally aggressive towards staff. Their care plans about these needs lacked detailed instructions for staff about how to manage situations where the person was verbally and physically aggressive or refused support with personal care.

When we discussed their care with staff, they were able to explain in detail how they managed these situations. They had undertaken physical intervention training which included de-escalation techniques. For example, when the person resisted care, staff spoke quietly to the person, chatting and reassuring them throughout their care. When the person refused care, staff approached them later to try again. If this didn't work, they showed us physical interventions and distraction techniques they used on occasions to provide the person with care in their 'best interest'.

The strategies staff described were in accordance with the services policies and procedures and techniques taught on managing challenging behaviour. However, the stepped approaches staff described and the techniques needed were not detailed in the person's care plan. Incident reports showed for a few people, these episodes of physical and verbal aggressions towards staff occurred frequently. This lack of detail in care plans about how to manage this increased the risks for others and staff, particularly for staff less familiar with the person and how to manage these behaviours.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two members of the community mental health team gave us positive feedback about staff skills and knowledge in managing people's challenging behaviours. They said staff recognised when people were becoming more aggressive and were proactive to prevent further escalation. They said staff completed challenging behaviour records before they visited, which helped to identify the triggers. This meant specialist staff had the information they needed to assess and review the person's mental health needs and to provide staff with appropriate advice. They also praised staff for the strategies they used to reduce anxiety and agitation for people living with dementia, rather than opting for medication. For example, they described how staff used weighted blankets sometimes to make people feel more secure when they go to bed. A relative commented that staff really understood the person's dementia and said that, although the person could be "Belligerent at times, staff always supported her using coaxing and positive support."

People at risk of malnutrition and dehydration had comprehensive individual nutrition and hydration care plans. Where concerns were identified, the person was referred to their GP, and some people were referred to dieticians for further advice. A list of people at risk were highlighted in red and had their food served on red trays to remind staff to record their eating and drinking accurately.

However, when we looked at people's food and fluid charts, records showed several people frequently received lower quantities of fluids than necessary to remain healthy and there were some gaps in food charts. For example, between 19 and 25 October, the fluid records for one person at risk of dehydration showed they had only had 300 mls one day, and 600 mls another day. This could represent inaccurate recording as our observations showed staff supported people who need assistance and encouragement with eating and drinking and they did not display signs of dehydration. People were offered hot and cold drinks regularly throughout the day and drinks were available in communal areas for people to help themselves to. Total fluids each person had taken in 24 hrs were not added up at the end of each day, although night staff were supposed to do this. This meant staff might not be alerted when people had not had adequate hydration and increased the risk of dehydration. Staff did not calculate each person's individual fluid requirements and staff had differing views about how much each person needed to drink to remain healthy and hydrated.

We discussed our concerns about the gaps we found in food and fluid charts with the registered manager. When we returned on the second day, they had implemented changes and improvements to these. Staff had used a tool to calculate recommended daily fluid intake for each

Is the service effective?

person at risk, and had changed the arrangements for totalling and checking food and fluid charts daily. They had raised awareness of these changes amongst staff and impressed on them the need for accurate record keeping.

Staff knew people's likes and dislikes and catered for any special food requirements, such as reduced sugar for people with diabetes. Staff were aware of people's dietary needs and the chef told us about the variety of methods they used to increase their calorie intake. For example, by adding cream, butter and grated cheese to potatoes and vegetables, and by making milkshakes and using nutritional supplements. A range of snacks, fruit, sandwiches, soups, jellies, full fat yogurts, honey and syrups were used. The chef provided 'finger foods', such as cubes of cheese and banana, that people who were restless could snack on whilst moving around. People at risk had their weight monitored regularly and further action was taken in response to weight loss, and several people had gained weight.

Where people had any swallowing difficulties, they had been seen and assessed by a speech and language therapist (SALT). Where the SALT had recommended soft or pureed food, each food was separately presented, which is good practice. Staffs had undertaken training and were aware of the importance of good positioning and of the need to give the person plenty of time to swallow between mouthfuls of food.

People and relatives all complimented the food choices available at the home. Food was a very important part of people's daily lives. Meals were home cooked and nutritional, and incorporated a range of seasonal vegetables and fresh fruit. There were seven lunch options to choose from on the daily menu, including a weekly special. These were all displayed in photographs and staff supported people to make their choice at lunchtime. For example, a pork and apple casserole, braised beef, haddock and chips.

People who wished to enjoyed a pre-lunch sherry. An attractive rotating glass cabinet displayed the choice of deserts, which included healthy options and choices suitable for diabetics. The serving hatch was decorated to look like an ice cream booth, and an ice cream cone was always available there. Staff were on hand to get each person's lunch for them and to support people who needed help to eat and drink. People's feedback about food choices was sought and their menu suggestions were implemented.

People's consent for day to day care and treatment was sought. Staff had undertaken training of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and most staff demonstrated a good understanding of how these applied to their practice. Where there were some minor inconsistencies, we discussed these with the registered manager who agreed to address them. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time.

Where a person was thought to lack capacity, mental capacity assessments had been undertaken. Relatives and professionals were consulted and involved in 'best interest' decision making. For example, in relation to moving and handling and personal care. Where people lacked capacity, some care records lacked detail to inform staff about how to support people with day to day decisions making, such as when they want to get up or what they want to wear. However, staff demonstrated to us how they supported people with those day to day decisions and choices. For example, using visual clues such as photos of meal choices, offering various options, and, through people's gestures, facial expressions, and body language.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. People's liberty was restricted as little as possible for their safety and well-being. For example, a careful assessment was undertaken whenever the use of bedrails or a pressure mat was considered for the person's safety.

The local authority DoLS team had authorised some restrictions of liberty for people's safety and protection, and staff were acting in accordance with these authorisations. The registered manager confirmed DoLS applications had been submitted for all other people living at the home who were awaiting assessment. This was because a number of people were under continuous supervision by staff and did not have the mental capacity to make a judgment about their own safety. The Supreme Court judgement on 19 March 2014 widened and clarified the definition of

Is the service effective?

deprivation of liberty. It confirmed that if a person lacking capacity to consent to arrangements is subject to continuous supervision and control and not free to leave, they are deprived of their liberty. These safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests.

People had access to healthcare services for ongoing healthcare support. They were seen regularly by their local GP, and had regular health appointments such as with the dentist, optician, and chiropodist. Where any health concerns were identified, visiting health care professionals confirmed staff at the home sought advice appropriately and followed that advice. A relative told us about a person who developed a chest infection, they said staff called the doctor and rang them straightaway to let them know. Another person remained in bed and was at increased risk of developing pressure sores. Their care plan provided staff with detailed instructions about the person's skin care, pressure relieving equipment and the need for them to be assisted to change their position regularly. The person said, "They are all very nice and helpful. I have to keep my legs propped up, they come to reposition me."

People were supported by staff who were knowledgeable about their health needs. When staff first came to work at the home, they undertook a period of induction. This included working alongside more experienced staff to get to know people and about their care and support needs. All new staff had to undergo a probation period and had their competencies assessed. This ensured they had the right skills and attitudes to work in care before they were given a permanent contract of employment. The provider had recently introduced the national skills for care certificate, which is a more detailed training programme and qualification for newly recruited staff.

Visiting health professionals gave us positive feedback about the standards of care provided and about the knowledge and skills of staff. One said, (the manager) "Is really good, always makes a point of seeing me, and interacts well with the patients and staff, no concerns at all." Another said, "This is one of the best homes in Seaton, they are very organised, and are always expecting us."

Staff felt well prepared for their roles, and had regular opportunities to update their knowledge and skills. Most staff had qualifications and several were undertaking further courses and qualifications, including the registered manager and deputy. They undertook regular update training such as fire safety, health and safety, moving and handling and infection control. We observed people being hoisted in the lounge area, and saw they looked relaxed and at ease.

Staff had lots of other training relevant to the needs of people they cared for. Where nursing staff made suggestions for additional training to support their external revalidation, this was being arranged. For example, update training on syringe drivers, catheterisation, and venepuncture was being arranged.

Staff received regular one to one supervision with a more senior member of staff. All staff had an annual appraisal where they had an opportunity to discuss their practice and identify any further training and support needs. The registered manager and deputy manager were trained to undertake 'Dementia mapping', a structured observation of staff practice, which provides feedback to staff to improve practice. Although this was only used on two occasions in the last six months, they said they used the principles continuously in their day to day practice. The provider said they had decided to reintroduce dementia mapping formally at a management meeting.

The environment of care was adapted to meet the needs of people living with dementia. People were able to move freely around communal areas and were assisted to identify toilets and bathrooms through picture and word signage. Although there was some signage in communal areas, the layout was difficult and confusing. We observed it was not that easy for people to find their way around, as staff needed to assist people several times who lost their bearings.

Hand rails, were available in corridors and bathroom areas to help people move around the home independently. There were chairs in corridor where people could sit and rest, watch and chat with others. The home was well lit, and well maintained, floor coverings were plain, rather than patterned, in accordance with best practice. Each person chose what colour they wanted their bedroom door painted, and architraves were painted a contrasting colour to help recognition. Each person displayed a picture that was meaningful to them on their door. These measures helped each person identify their room more easily.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff who treated them with warmth and compassion. One person said, “They are so good, absolutely ideal, nothing is too much trouble.” Another said, “I absolutely love it here, staff are very obliging, food is very good, and visitors are made welcome.” A relative said, “They treat people in a respectful way.” Another relative contacted CQC directly to provide feedback. They said, “All the staff who were involved in my dad's care were caring, calm, compassionate and professional, both in how they cared for him and in how they dealt with us, his relatives.”

Staff described the ethos of the home as being like an extended family. They spoke about their role as being there to support the running of that family home, in the interests of the people living there. A sign in the main corridor captured this ethos. It said, “Our residents do not live in our workplace, we work in their home.”

Where needed, people had access to advocacy services, so their views were independently represented. An advocate visiting the service said, “The care here is amazing; it is my care home of choice. Staff are very kind and caring and there are enough staff to give people more time”

Staff knew people, their likes and dislikes, and established a rapport with each person. Staff

spent time with people, they chatted and listened to them, were patient, kind and encouraging. There was lots of fun and laughter, spontaneous singing and dancing, and holding hands. Staff responded sensitively and compassionately when a person who became tearful and upset, they guided them to a chair and sat with the person, holding their hands and reassuring them. Another staff member noticed when a person was anxious and asked them to look after a cuddly toy animal. The person responded to this and calmed quickly. Care staff gently woke a person to offer them lunch; they praised and encouraged them, by saying “You are doing really well.”

Staff treated people with dignity and respect. One relative said the person was extremely particular about their personal appearance and they valued that staff knew that. They always supported the person to have their hair done in their choice of style and to wear co-ordinated clothes. Staff knocked on people’s bedroom doors and waited for a response before entering. They discreetly asked people whether they wanted to use the toilet. Bedroom, bathroom and toilet doors were kept closed, when staff were supporting people with personal care. Staff maintained confidentiality and never spoke about a person in front of other people. At mealtimes, assistance was provided with eating in an unhurried and dignified way and where needed, people’s clothes were protected from spills.

People were able to sit and talk with visitors in a quiet, private space. Health professionals said when they visited, people were always taken to their room so they could be seen and examined in private. People had single rooms, with the exception of one double room which accommodated a couple to remain together who both needed care and support.

The provider focused on food and meal times as way of promoting and maintaining positive relationships and experiences. Lunch was a very social occasion with people sitting together and chatting. A relative was pleased with the efforts staff at the home made to prepare vegetarian options for one person. They said, “staff make eating a grand occasion.” The chef emphasised the importance of maintaining food as part of celebrations. Each person’s birthday was celebrated with a birthday cake. They prepared special menus for Easter and Christmas and treated these events as a big family celebratory meal. They said they liked to create a sense of tradition on these occasions, such as, getting a person living at the home to carve the first slices of turkey at Christmas.

People were supported with their communication needs. In one person’s room, staff had put up a notice to remind them to take their hearing aids with them when they left their room. For another person, who could not communicate verbally, staff had compiled a book of pictures/words to help them communicate their daily wishes and preferences. For example, "Can you help me please, I am in pain, and may I have a cup of coffee." One person who lived at the home spoke German, as could a member of staff so they enjoyed speaking together.

People and relatives were consulted and involved in decisions about their care. For example, about the use of pressure mat in a person’s room to alert staff when the person needed help to try and reduce their risk of falls. Where people had nominated a relative as a Lasting Power of Attorney (LPA) to make decisions about their care and treatment, staff involved them appropriately in decision

Good

Is the service caring?

making. LPA is a way of giving someone a person trusts the legal authority to make decisions on their behalf, if either they are unable to at some time in the future or no longer wish to make decisions.

People's religious beliefs were supported, and there was a regular service at the home. People were asked about where and how they would like to be cared for when they reached the end of their life. Any specific wishes or advanced directives were documented, included the person's views about resuscitation in the event of unexpected collapse. The home worked closely with hospice nurses to provide end of life care. Feedback highlighted the support and compassion shown by staff to people having end of life care and to their families. Letters from a health professional complimented staff on their sensitivity and caring. For example, one letter said, "He was a very religious man and the tact and sensitivity your staff showed made a huge difference."

Staff supported two people to continue to care for their beloved pets. One person had a cat and another had a budgie staff helped them to care for. The home also had a dog, who circulated around communal areas of the home, and was very popular with people.

Good

Is the service responsive?

Our findings

People living in the service received personalised care which met their needs. One person said, "I can go to anyone in this home and they act; I can ask them something and it happens immediately. That is the difference here; things get done!" A relative said, "The best thing about this home is they offer holistic, personalised support. Staff continue to do what is a priority for him." A visitor said, "They put the residents first; it is all resident-centred …they change the systems to suit the individual."

Staff had a good knowledge of people's individual needs; people were offered choices about their daily lives and staff worked flexibly around their wishes. For example, what time the person wanted to get up and go to bed, where and when they wanted their meals.

Each individual was supported with person centred care plans, which were written in the first person, and reflected how individuals said they liked to receive their care and support. They included information about what the person could do for themselves and what they needed staff to support them with. For example, one person's said, "I sometimes like to help around the house. I do not like to be told what to do. I often cannot find the words and that upsets me."

A personalised sheet, provided a summary of the person's care needs, and the day to day support they required. This meant staff who didn't know the person well could see at a glance how to support them, and could refer to their more detailed care records for further information. Care records were reviewed and updated regularly as their needs changed. Daily records provided information about the care provided, and about people's physical and psychological wellbeing, and how they spent their day. Staff compiled detailed life histories about each person, their family and their life before they came to live at the home. They used the Alzheimer's society 'This is me' tool to capture this information.

Each person had an individual activity records about their individual interests and hobbies. For example, one person had a great interest in model trains and staff helped them to assemble the rail track in his bedroom. They also had a love of 1950's music and which they enjoyed listening to regularly.

Two visitors commented positively about the variety of activities available for people living at the home. One said, "We are very impressed with the home, there is always something going on for people." The Check House employed six activity co-ordinators who provided a range of activities which supported people to socialise and interact and learn new skills. There was a weekly activity programme which included a wide variety of choices for people. These included games and puzzles, dominoes, ball games, singing, dancing and musical entertainment. There were a variety of books, magazines and newspapers available for people to enjoy. There were regular art and poetry classes which several people enjoyed. A hairdresser visited weekly and regular aromatherapy massage and manicures were offered.

However, it was more difficult to ascertain how people who remained in their room, through choice or for health reasons, were supported to socialise and maintain their interests. Activity staff said they visited each person in their room daily. For example, to have a chat, look at pictures, and to support the person to listen to audio books, music or the radio. However, when we looked at daily activity records for two people who were nursed in bed, we saw entries were much the same each day. For example, "Had a chat, put music on", or "In bedroom relaxing with the radio on". This meant it was not clear how activities supported the person's individual needs and interests.

Activities took into account the needs of people living with dementia and were designed to help people reminisce, and stimulate conversation. For example, for one person staff had compiled a file of pictures and stories about the Manchester United football team, which was a great passion for them. Staff used this as a talking point to try to engage in conversation with the person and prompt them to recall their own experiences of the club. Other sensory activities included art and crafts, listening to music, singing and dancing. There were lots of areas of interest around the home to stimulate people living with dementia. For example, tactile objects for people to pick up, posters and pictures on wartime themes, and vintage advertising signs.

Staff involved people who wished to in helping around the home, which gave them a sense of purpose and satisfaction. One person helped with folding napkins, photographs showed people helping with vegetable preparation and doing some vacuuming.

Good

Is the service responsive?

Each person's room was personalised with things that were meaningful for them. For example, people were encouraged to bring family photographs, pictures and any furniture or ornaments precious with them when they moved into the home.

People were supported to remain as active and independent, as possible. Each person had a personalised mobility and exercise plan, staff reminded people to use their mobility aids when moving around the home, in accordance with their care plan. Regular fitness and exercise classes were provided included seated Tai Chi.

People were supported to access their local community and go out on trips. One person told us they liked going to Tesco to do a bit of shopping and were looking forward to visiting Axminster market on Thursday, a trip they had suggested, which the provider arranged.

People were encouraged and supported to develop and maintain relationships that mattered to them. Family and visitors felt welcome and were encouraged to visit and be involved in the home. People could invite family and friend into the home for a meal and were able to eat lunch in privacy in a separate area. There was a bar area known as 'The Snug Inn' where people could chat and enjoy a drink with others. In the main lounge there was a juke box area with memorabilia on the walls and there was an attractive shop where people could purchase sweets and toiletries.

People and relatives said they felt happy to raise concerns with the registered manager or any staff and were confident it would be dealt with straightaway. The provider had a written complaints policy and procedure. Written information was given to people and was on display in the home about how to raise a complaint. The registered manager dealt proactively with grumbles before they became formal complaints. Two complaints had been received in the past twelve months. The complaints log showed these had been appropriately thoroughly investigated, responded to, apologies offered appropriately and improvement actions taken. We spoke with a relative who had made a complaint who said the provider and registered manager responded positively and proactively to their concerns.

Good

Is the service well-led?

Our findings

People, relatives, staff and visiting professionals all gave us positive feedback about the home. One said, "I never have any worries they always contact me if they are worried." The culture of the home was open and friendly. Care was organised around the needs and wishes of people. A relative said, "Staff treat mum as a human being and treat this place as her home."

The registered manager said, "We have a good team a family feeling." Staff were positive about working at the home. Their comments included, "I like being here, I like the environment, " and "It's is a nice house we all get on well with each other … the way they (people) are looked after is brilliant." Another said, "This is the best place I have ever worked, it is well led and I feel valued"

The registered manager, deputy manager and clinical lead nurse were visible around the home. They monitored practice, provided advice, feedback and support to staff. A member of staff said, "They are amazing role models; they are not just your boss; we are one big work family." Speaking about their leadership style, the registered manager said "I wouldn't ask the staff to do anything I wasn't prepared to do myself." Staff described them as approachable, responsive to concerns and said they appreciated their 'hands on' approach. One staff said, "There isn't a job in this home that she cannot or won't do; she won't let anything fall short". Another said, "Very supportive, it's amazing how much she notices and takes the time to speak to you and asks if you are alright."

In the provider information return (PIR), the provider outlined ways through which the provider promoted best practice. Staff training was based on advice from the specialist dementia group at Bradford University. The provider used the 'Progress for Providers' guidance to help staff deliver personalised support for people living with dementia. The service participated in the Dignity in Care initiative, and had a certificate of commitment about ensuring people are treated with dignity and respect. Several staff had signed up to the Alzheimer's society 'Dementia Friends' champions, to promote best practice in encourage people living with dementia to live well. The service had recently started a relative's support meeting, which was very popular. This was to build a network of relatives to provide each other with support, advice and suggestions about how to improve people's wellbeing.

People views were sought, residents/relatives meetings were held regularly and there was evidence of continuous improvements being made in response to people's feedback. For example, feedback about the food choices were sought through a survey and changes and improvements made in response.

Accidents and incidents were monitored to identify themes and trends and actions taken in response. For example, in relation to falls risks and managing challenging behaviours. The provider had introduced additional staff training and had recently extended the activity co-ordinator cover to cover five till seven each evening. Staff said this reduced the episodes of behaviours that challenged the service during this period, as people were occupied when care staff were busy assisting people back to their rooms. A visiting professional who sometimes visited the home in the evening said how impressed they were that people were still up and dressed. They said this was in contrast to their experience in other homes where people were dressed for bed very early in the evening.

Staff were consulted and involved in decisions making about the service through regular staff meeting and said they felt listened to. One staff said, "Every time I suggest something I get it, (the manager) respects my decisions." A staff survey was in progress when we visited.

Staff had access to a range of policies and procedures to guide their practice, which were regularly reviewed and updated. There was also a 'staff library' in the manager's office with additional information and resources on a range of topics such as the Mental Capacity Act, Deprivation of Liberty, and positive care techniques to reduce the need for physical interventions.

The provider had a range of quality monitoring systems in use which were used to continually review and improve the service. These included regular health and safety checks and local audits of medicines, care records and infection control. However, the records audit tool used did not identify the lack of detail in care plans about managing behaviours that challenged the service or the gaps in food and fluid charts identified during the inspection.

Provider visits were regularly undertaken by the area manager and the registered provider. They met with people and relatives, looked at care records, at how people's nutritional needs and at how other risks were managed. Action plans showed any areas for improvement identified

Good

Is the service well-led?

were acted on. Any concerns about practice and staff performance were dealt with promptly through training, supervision and the provider's capability and disciplinary procedures.

The provider spoke about their aim to continuously improve the service. They said, "We are immensely proud of the home. Whatever we are doing today, we want to be doing it even better tomorrow." Regular management meetings with the registered managers of all homes within the group. Minutes of meetings showed issues were discussed, decisions made and good practice ideas shared. For example, one theme identified was increasing difficulty in recruiting staff. In response, the provider implemented a number of measures to recognise and reward existing staff for their service. This included a salary increase, recognising and celebrating staff birthdays with a cake and gift voucher and additional leave for long service. The September minutes showed these initiatives were working well and were appreciated by staff.

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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Risks for people were increased because care plans about managing people whose behaviours challenged the service lacked detailed instructions for staff. This is a breach of regulation 17 (2) c.