Gittisham Care Limited

Gittisham Hill House

Inspection report

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Date of inspection visit:
05 January 2016
07 January 2016

Date of publication:
22 February 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This unannounced inspection took place on 5 and 7 January 2016. We last inspected the service in October 2013 and found it was compliant with the standards inspected and there were no breaches of regulations.

Gittisham Hill House is registered to provide accommodation for a maximum of 39 people who require nursing and personal care. The home is situated near Honiton, Devon. The service specialises in the care of older people, most of whom are living with dementia. When we visited 36 people lived at the home, 19 of whom were receiving nursing care.

The service has 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 and associated Regulations about how the service is run.

People who used the service, relatives and health and social care professionals were impressed with the service and how people were treated. One relative said, "We are extremely satisfied with the care, she is looked after really well." A health professional said, "A very nice place with nice people."

People received effective care, based on best practice, from staff that had the knowledge and skills needed to carry out their role. Health and social care professionals consistently gave us positive feedback about the kindness, care and support provided for people. A visiting professional said, "The residents provided with a safe environment and their care is effective."

People gave us very positive feedback about the food choices at the home. One person said, "We are well looked after with food." People were supported with nutrition and hydration, although improvements were needed in adding up fluid records of what people at increased risk of dehydration had drunk each day.

The environment of care was adapted to meet the needs of people with physical disabilities and those living with dementia. The buildings have been significantly improved and refurbished with further improvements planned. The home had lots of areas of interest for people to sit, enjoy and spend time in. Some people who were restless were freely able to access all communal areas on the ground floor and go upstairs whenever they wished.

There was a calm and relaxed atmosphere in the home on both days we visited. The ethos of the service was that it was people's home and staff respected people's individual choices. Staff interacted in a kind and respectful way with people. For example, when a person became upset, staff noticed immediately and intervened to reassure them. Staff were friendly and cheerful and they knew each person well, what they liked to be called, their preferred routines; and their social and family history.

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 said they felt safe living at the home. Staff were aware of signs of abuse and knew how to report concerns, any concerns reported were investigated. A robust recruitment process was in place to make sure people were cared for by suitable staff. People knew how to raise concerns and were confident any concerns would be listened and responded to.

The service was well led. People, relatives and staff said the home was organised and well run. The culture of the home was open and friendly. Staff said they worked well as a team and felt supported and valued for their work. Senior staff acted as role models to support staff to achieve high standards of care.

The provider had a range of internal and external quality monitoring systems in place, which were well established. There was evidence of making continuous
improvements in response to people's feedback, the findings of audits, and of learning lessons following accidents and incidents.

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 were protected because staff knew how to recognise signs of abuse and how to report suspected abuse.

People's risks were assessed and actions taken to reduce them as much as possible.

People received care and support at a time convenient for them because staffing levels were sufficient. Staff had been safely recruited to meet people's needs.

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

Is the service effective?

Good

The service was effective.

People were cared for by skilled and experienced staff. Staff 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).

People experienced a level of care and support that promoted their health and wellbeing. Staff recognised any deterioration in people's health, sought professional advice appropriately and followed it.

Is the service caring?

Good

The service was caring.

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

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

People were treated with dignity and respect and care was organised around people's needs.

Is the service responsive?

Good

The service was responsive.

People received personalised care from staff who knew each person, about their life and what mattered to them.

There was a varied programme of activities. People were encouraged to socialise and pursue their interests and hobbies.

People and their relatives felt confident to raise concerns. There was a complaints process, any complaints raised were investigated and positive action taken to improve.

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.

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

Gittisham Hill 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 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.

The inspection took place on the 5 and 7 January 2016 and was unannounced. An inspector and an expert by experience carried out this inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses a dementia care service.

Prior to the inspection we reviewed all information we held about the service. This included looking at the Provider Information Return (PIR), previous inspection reports and notifications the provider sent to us. A notification is information about important events which the service is required to tell us about by law.

We met most of the 36 people using the service, spoke with 16 of them and with three relatives and we looked at five peoples' 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 ten staff, and looked at five staff records, including staff recruitment, training, supervision and appraisal records. We looked at the provider's quality monitoring systems such as audits of records, health and safety audits, monthly reports to the provider and provider visit reports.

We sought feedback from health and social care professionals who regularly visited the home including GP's, community nurses, and other therapists as well as commissioners and received a response from five of them.

Good

Is the service safe?

Our findings

People felt safely cared for at the service. One person said, "Staff are kind.....no one would do us any harm". Another person said they had been cared for upstairs previously but had been moved downstairs so that staff could keep a closer eye on them. Relatives who visited the service regularly said, "I have never seen or heard a carer being cross nasty or short with anybody" and "The care is safe and I have no concerns whatever....they would never do anything unkind."

Staff received training in safeguarding adults and were familiar with the types of abuse that should be reported. All staff said they could report any concerns to the registered manager or deputy manager and were confident they would be dealt with. One said, "There is guidance in the staff room, and I would go to a senior." The provider had safeguarding and whistle blowing policies available so staff were clear how to report concerns. Any safeguarding concerns identified had been notified to the Care Quality Commission and the local authority safeguarding team. They had been investigated and actions taken to protect people and keep them safe. Whistleblowing policies were in place and were discussed with staff, to reassure them they would be protected if they raised any concerns in good faith.

People needs were met at a time convenient for them. Staff were busy but worked in an organised way and spent time with people. Where a person needed two staff because of moving and handling or behaviour needs, they were always available. At lunchtime, each person who needed help to eat was supported by staff to do so. Staff responded promptly to call bells, although one person called out upstairs for a while. Most relatives thought there were enough staff, although one relative said, "I wish there were more staff". They said this was because staff didn't always have time to check when the person had wriggled into a difficult position. Where people were confined to their rooms, records showed staff checked on people regularly.

The service used a dependency assessment tool to assess staffing levels needed, which was based on each person's individual needs. The registered manager had recently reviewed staffing levels in the home over the 24 hour period, and looked at call bell response times. From this they identified additional staffing needs early each morning when people were getting up and in the evening when people were going to bed. They also identified the current night staffing levels were not always needed. So they were in the process of moving some hours to daytime, and were recruiting additional staff so they could respond more flexibly to times of peak demand.

There were sufficient numbers of staff on duty to keep people safe and meet their needs. Most of the staff were experienced and had worked at the home for several years, so new people well. However, the registered manager said recruiting skilled nurses was the biggest challenge they faced. Currently, the home had a nurse vacancy and another nurse was due to leave for career development but was planning to join the staff bank, so would continue to work some shifts. The service had been unsuccessful in recruiting a replacement nurse when they advertised and were now using a recruitment agency to help with this. From this they had identified a potential applicant, which they were following up. Any gaps in staffing were met by existing staff working extra shifts and by the use of regular agency staff, who had got to know people living at

the home.

Individual risk assessments were undertaken to identify, manage and reduce risks. For example, risks of falling, moving and handling risks and risks of developing pressure sores from fragile skin and reduced mobility. Risks were reviewed regularly as people's needs changed and instructions in care plans showed actions being taken to these reduce risks as much as possible.
Accidents and incidents reported were reviewed to identify ways to reduce risks for each person as much as possible. For example, previous accident reports highlighted some people were up and restless at night and there were several 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. They also arranged for those people to be reviewed by their GP who reviewed their care and medicines, and these measures had reduced those risks.

People received their medicines safely and on time. The service used a monitored dosage system on a monthly cycle for each person. Staff who administered medicines were trained and assessed to make sure they had the required skills and knowledge. Staff stayed with the person whilst they were taking their medicines and provided encouragement and support, where needed. Where people had medicines prescribed, as needed, staff checked with the person, for example, asking them whether they needed any medicine for pain.

Medicines administered were well documented in people's Medicine Administration Records (MAR), as were records of prescribed creams applied. Where a person's dosage of medicines was altered, there were systems in place to make sure the prescription was updated accordingly and the correct dosage obtained. Where people needed their medicines at a particular time for their health condition, this was arranged. Some people who experienced behaviours that challenged the service had medicines prescribed for mood, as needed. For example, one person was prescribed a relaxant drug for when they became restless or agitated. The prescription gave clear details about the circumstances in which this should be used, starting with the smallest dose, and reviewing to see if this was effective before giving any more. The use of as required medicines for people's behaviour was closely monitored and their use was minimised.

All medicines were securely stored and all stock entering and leaving the home were accounted for. The temperature of the medicines room and the medicines refrigerator were monitored to ensure medicines were stored at manufactures recommended temperatures. Medicines were audited regularly with actions taken to follow up any discrepancies or gaps in documentation.

People were cared for in a clean, hygienic environment and there were no unpleasant odours in the home. One relative said, "When I visited, to see if the home was I said to myself, golly it smells clean." Staff washed their hands regularly and used gloves and aprons when providing personal care.

There was a team of cleaning and housekeeping staff. Written cleaning schedules were completed for all areas of the home. Cleaning staff used colour coded mops and cloths for cleaning different areas of the home to prevent cross infection. Furniture, wheelchairs and other equipment were cleaned regularly. Heavily soiled laundry was segregated and washed at high temperatures in accordance with infection control guidelines. There were infection control policies and procedures to guide staff and regular audits were carried out, with action taken to address any issues.

Environmental risk assessments were completed for each area 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.

There was an ongoing programme of repairs, maintenance and refurbishment to improve the environment of the home. The older part of the building had been refurbished to high standard and new furniture purchased. The registered manager told us about plans to replace the windows next year and they were hoping to get agreement to install another 'wet room'.

Equipment was regularly serviced and tested and regular checks of the fire alarm system, fire extinguishers, smoke alarms, and fire exits were undertaken. 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.

All appropriate recruitment checks were completed to ensure fit and proper staff were employed. Staff had police and disclosure and barring checks (DBS), 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. For existing staff, a DBS check was made every three years. Checks were also made to ensure nurses were currently registered with the Nursing and Midwifery Council.

Good

Is the service effective?

Our findings

People felt well supported by staff who were appropriately trained and knew how to care for them. One relative said, "The standard of care is very good." 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. New staff were undertaking the national care certificate, a nationally recognised set of standards that health and social care workers are expected to adhere to in their daily working life.

Most staff had qualifications in care or were undertaking them. Staff undertook regular update training such as safeguarding adults, health and safety, and infection control. Staff felt well supported to do their job. 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.

Staff said there were excellent training opportunities at the home. One staff said, "I really like it here, I feel well supported, another staff said their mentor had been "incredible." They were now planning to train to be a nurse. Staff described a recent two day dementia training they had attended, which they had really enjoyed. They described what they had learned about the different types of dementia and how it affected people in different ways. In October 2015, the registered manager arranged for the trainer to provide a dementia awareness day for relatives and family member on a Sunday, which was really well attended and popular. The registered manager said, "People absolutely loved it."

A nurse did the initial assessment of each person's needs before they first came to live at the home to ensure staff could meet their needs. For example, where a person was confined to bed because of their health needs, their care plan instructed staff on actions to take to prevent skin damage. The person had a pressure relieving mattress, staff helped them to have regular changes of position, provided personal care and skin care. However, the care plan did not document the setting needed for the pressure relieving mattress. When we asked about this, the deputy manager said the mattresses in use at the home alarmed if they were not set correctly for the person's weight, but agreed to add the recommended setting to the person's care plan.

A relative said they were impressed with the skin care given to the person, who did not have any sore areas. Where any concerns about skin damage were identified, these were referred appropriately for advice. Any skin wounds were recorded on a body map and photographed. This was so they could be closely monitored for healing and to check the effectiveness of the treatment being used.

People were supported to access healthcare services such as attending regular appointments with their dentist, optician and any hospital appointments. People were regularly visited at the home by their GP, the community mental health team, and the district nursing team visited people not receiving nursing care at the home. For example, a district nurse visited one person regular to help monitor their diabetes.

Health professionals confirmed staff contacted them appropriately for advice. One said, the deputy

manager, "Is an experienced and caring nurse who ensures that the patients' best interests are served in their care." Another health professional said, "It is excellent, I can see that everybody is being treated well and they have their needs met". A mental health professional said staff knew people and managed any behaviours that challenged the service well. They said staff followed advice include documenting any behaviours and how they managed them. This meant they could provide appropriate support and advice, including medication advice, when they visited.

Another professional said the registered manager contacted them to seek advice about equipment and was always willing to purchase equipment needed to meet people's individual needs. For example, a tilt in space shower chair. There was lots of moving and handling equipment available in all areas of the home. Detailed moving and handling plans showed the number of staff and any equipment needed. Where a person needed hoisting or help to move in bed, they had individual hoist slings and sliding sheets in their room suitable for their weight and size. Two people were skilfully transferred from chair via hoist to a wheelchair to go into dining room for lunch. Staff gave each person clear instructions at a suitable pace and encouraged the person to assist. They offered praise and encouragement throughout and checked each person was comfortable afterwards.

People had a choice of main meal. The chef visited each person daily and helped them to choose their meals. A board displayed 'Todays Menu' with photographs of meals to remind people what was on offer. People gave us very positive feedback about the food choices at the home. One person said, "We are well looked after with food," another said "The food is good....I do have a choice," and a third said, "They know our likes and dislikes." Kitchen staff had information about each person's dietary needs. For example, that some people needed a pureed diet because of choking/swallowing risks. Reduced sugar alternatives were available for people with diabetes.

Mealtimes were very sociable occasions, some people ate lunch in the dining room and others ate in their rooms or in the lounge area. Adapted cutlery and plates were used to support some people to eat independently. Each person who needed assistance was brought their meal by the staff member who was helping them. This meant the food was warm and they didn't have to wait.

Some people who lived at the service were assessed as being at increased risk of malnutrition or dehydration. For those people, care plans instructed staff to monitor the person's food and drink intake, as well as checking their weight regularly. Where people had a poor appetite or were unwell, staff tried a variety of ways to tempt them to eat. One relative described how the person had stopped eating when they were first admitted but had regular nutritional supplements and has now gained nine pounds. Weight charts showed staff were managing people's weight well, and taking action to address weight loss. For example, in October 2015 the monthly nutrition report identified five people were losing weight. They were referred to the dietician for advice and support and had since gained weight.

People were offered hot and cold drinks regularly throughout the day and staff assisted people to drink. Staff communicated what people had eaten and drunk, and alerted one another when a to try again later when a person hadn't eaten or drunk much. Although people's fluid charts were mostly well completed, they were often not added up at the end of each day, which they are supposed to be. This meant staff might not be alerted when people had not had adequate hydration. Care plans for people at risk of dehydration did not give staff any guidance about how much each person needed to drink to remain healthy and hydrated, although no one showed signs of dehydration. We discussed this with the registered manager and clinical lead who said they would work on addressing this. They reminded senior staff about their responsibility for adding up fluids at the end of each shift, which had improved on the second day of our visit.

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

People's consent for day to day care and treatment was sought. For people who appeared to lack capacity, mental capacity assessments were completed. Where a person was assessed as not having the capacity to make a decision, people who knew the person well and other professionals, were consulted and involved in making a decisions in the person's 'best interest'. For example, in relation to the use of bedrails.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found staff had a good understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice. One person living at the home had a Deprivation of Liberty authorisation in place, which staff were acting in accordance with. Applications had been made to the local authority DoLs team for most of the other people living at the home, who were awaiting assessment by members of the local authority DoLs team. 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.

External doors were locked and had key code access. This was because most people who lived at the home could not go out unaccompanied, and needed staff or relatives to accompany them for their safety. Several people's rooms were locked when they were in other areas of the home, and we saw one person trying to get into their room. We asked about this and the registered manager said where rooms were locked, it was because of a risk of them going into other people's rooms. The regional manager said they were looking at this to see if better solutions could be found, such as electronic fobs that would allow people to go into their own rooms, but not anyone else's.

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. There were wide corridors for easy access, hand rails in corridors and bathroom areas to help people move around the home independently. There were chairs grouped in alcoves where people could sit and rest, watch and chat with others. The home was bright, well decorated, floor coverings were plain, rather than patterned, in accordance with best practice.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff who treated them with warmth and compassion. They looked comfortable and relaxed with staff and care was respectful, kindly, and patiently delivered. One person said, "They look after us very well...it is very very good here" and "I would recommend it to a friend...as a home it is brilliant....they all know their jobs." Another person said, "It is very nice and they are very kind." A relative said, "I honestly found everybody extremely kind and always …the ethos is great." Another said, "They are so patient with people with dementia."

A health professional said, "When I have visited I have always been impressed with the caring attitude of the staff towards the residents and the relaxed and cheerful atmosphere." They went onto say they had recommended the home to a friend for a family member living with dementia and anxiety. Another health professional said, "Residents appear settled, the atmosphere is calm and the staff care for the patients and treat them kindly. "Another said, "Patients are given privacy to see me alone if they prefer this or are supported by the nurse if they prefer." A staff member said, "There is a really fantastic level of care...it is very good ....you can see the compassion."

People were treated with dignity and respect. The registered manager had signed up to the national 'Dignity in care' initiative and had a certificate of commitment to uphold the good practice steps. At mealtimes, people's clothes were protected where needed. Staff noticed when a person spilled their drink, attended to them immediately, reassured the person and accompanied them to their room to change their clothes. Another person had just been to the hairdresser and enjoyed several compliments from staff and others. A chiropodist visited regularly for foot care, and staff offered manicures and nail care and cutting each week. One relative identified teeth brushing as an area for improvement. They said, "I have spoken to the manager about (the person's) teeth....he has his own.....she responded, but it has been inconsistent....sometimes I do it". A staff member maintained a person's dignity and privacy by adjusting their trousers before they went into the dining room for lunch. They reminded the person where they were going, advised them to "mind the step" and thanked them.

Staff interacted well with each person in a caring, and respectful way. There were lots of gestures of care and affection, and lots of laughter. Staff demonstrated empathy in their in their discussions with us about people. Staff were visible around the home, spent time with people and were interested in what they had to say. One person who could not speak was supported to communicate with staff using a simple tool to indicate their choice and how they were feeling. Support staff such as cleaning and maintenance staff were equally confident and caring with people. For example, a member of the maintenance team chatted to a person and addressed them by their name. All staff who worked at the home did the training programme on privacy and dignity, rights and respect.

Staff described the ethos of the home as being like an extended family. The registered manager emphasised to staff that that Gittisham House was people's home first and a work place second. The registered manager said, "We are a family, it's not just a care home, it's a home."

Relatives and families were welcomed into the home. A person said, "My husband is treated very nicely he gets a cup of tea or coffee and he can come for Sunday lunch". A visitor said, "They are kindly to visitors and give them a cup of tea and a biscuit." On Christmas day staff at the home had arranged for 20 visitors to come and eat Christmas lunch with their loved one. The registered manager described how they had arranged tables in different parts of the home so each family could enjoy a private family celebration.

Responses from surveys of people and relatives also showed they were very satisfied with the care provided at the home. Comments included, "As a family we are very pleased with the care and attention given to (person's name)." Another said, "We cannot praise staff highly enough and try and say thank you regularly for the job that you do." And "We are extremely pleased with the level of care we have witnessed."

One relative who attended the dementia awareness day said they had appreciated this. Following the success of the dementia awareness day for families in October 2015, the registered manager was helping relatives to set up a support group. The first meeting was due to be held at the end of January.

People's religious beliefs were supported, and a local vicar visited the home occasionally. They 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. A letter from a health professional complimented staff on their sensitivity and caring.

Good

Is the service responsive?

Our findings

People living in the service received personalised care which met their needs. Staff knew people well, understood their care and treatment needs and cared for them as individuals. They told us about some people's lives before they came to live in the home, what jobs they used to do and about their families. 'Life maps' were used to record this information about each person. A relative commented, "The staff know her and indeed she responds more to them than to me."

Staff communicated any new information about each person during the day and during staff handover, such as that one was feeling unwell. Staff worked flexibly around people's needs and offered people choices. For example, people chose what time they wanted to get up and go to bed and how they spent their day.

People and relatives were consulted and involved in decisions about their care. Each person was as involved, as able, in an assessment of their needs when they first came to live at the home. Care assessments and care plans were signed by the person and a relative, where appropriate, to show they agreed with the records. Six monthly review meetings were held which relatives were invited to participate in with the person.

Care records had information about each person, and care plans informed staff about people's health and social care needs. They included information about each person's communication, physical and psychological needs and their levels of cognition. These were reviewed and updated regularly. However, they were a number of folders in use, each of which had information about the person's care. This, and the number of care plans for each person, meant records took a long time to read and relevant information could not always be located promptly. This could increase risks for people, particularly where staff were less familiar with the person and their needs, such as n agency staff.

For example, one person who lived at the home sometimes displayed behaviours that challenged the service, and could be verbally and physically aggressive. Staff described in detail how they managed this person when their behaviours were escalating, such as by using distraction techniques and how they needed two staff sometimes to care for the person. However, this information was in a variety of places in their care records, such as their personal care plan, their mental health care plan and in their moving and handling plan. In the provider information return (PIR), the registered manager highlighted the provider's plans to review the current care plan system in use.

We followed this up at the inspection and the regional manager said that currently they were exploring options for replacing the paper based system with a more person centred electronic record system, but had not yet chosen a preferred one. This showed the provider had identified the need to improve their current care record system and was working on it. In the meantime, in two of the records we looked at, we saw staff had started to create summary information for each person. This was so that staff not familiar with them would be able to access key information about them quickly in order to provide their care.

Each person's room was personalised for their needs. For example, with family photographs, favourite

pictures, furniture, ornaments and colourful throws. Care records included details about people's individual preferences. For example, how one person liked their breakfast in bed, enjoyed coffee and preferred savoury foods. Another person had brought their piano when they came to live at the home and regularly went and played it and started impromptu sing songs. Staff said they had led the carol singing at Christmas, which everyone had enjoyed.

People had been involved in choosing the decorating scheme and pictures for the home. Each person had a glass fronted box on their bedroom door with pictures and objects meaningful to them, which also helped them locate their room. One area for improvement identified by some relatives and staff were opportunities to go outside. A relative said the person said no to everything staff offered them, but felt they could be persuaded to go outside. The outdoor space around the home was quite small, and staff said they needed to accompany people in the garden as it wasn't that secure.

The service had an activities co-ordinator who provided a range of activities for people to enjoy. Each person was given a weekly agenda of activities planned. This might include music, games, a 'past and present' quiz, and cooking. There were floor games such as Ludo, baskets of cuddly toys and dressing up clothes, for fun. Photographs displayed around the home showed people enjoyed cookery sessions, painting, and games. A range of jewellery people had made was in a display cabinet. The co-ordinator visited people in their rooms and did one to one sessions on areas of interest to each person which helped to prevent isolation. For example, reading to one person and playing scrabble with another. A relative said, "The number of times staff pop in and out is excellent." Where people were confined to their rooms, they often had a TV or radio on in the background for company, and staff popped in regularly. One relative said, "He sleeps a lot and some kind person thought of putting radio three on for him and he seems to take pleasure in this."

When we visited, the activities co-ordinator was on holiday and was much missed by people and staff. A member of care staff led a word quiz in the lounge before lunch that 13 people were interested and participated in. In the afternoon, several people and staff played music and danced. Staff had put opera music on in the small lounge which people seemed to be enjoying. Records of activities were available for each person to show what they did, and what they enjoyed, although these hadn't been completed by staff since the 24 December, when the co-ordinator went on leave. There were books and a variety of other things to interest people in areas all around the home. We saw someone enjoying a moment in a quiet room with a picture book. Staff said some people also liked to help around the home sometimes. For example, one person liked to help clearing plates after meals and others helped with folding napkins.

Feedback from people and relatives was sought through six monthly questionnaires and review meetings. The registered manager said they were hoping the relatives support group would be a good forum for relatives to support one another, and for staff to get feedback and ideas about any suggested improvements. This showed the service was committed to seeking feedback and making improvements in response.

A service user handbook was available in each person's room, and the complaints procedure was available in the main entrance hall. The registered manager also sought feedback from visitors to the home using a complaints and grumbles book in the front entrance, but this was poorly utilised. They were in the process of replacing this with a comment card system to get feedback, which people could put in a locked box.

In the PIR the registered manager outlined changes and improvements made in response to complaints. For example, increasing housekeeping hours, providing laundry baskets for each person, a greater range of activities for people and training for families about dementia.

We sampled how the service responded to two complaints received. These were investigated and actions taken to make improvements I response. The registered manager wrote a written response outlining their findings, offering apologies and explanations about improvements made. This showed the service was open to criticism and used complaints as opportunities for learning and improvement.

Good

Is the service well-led?

Our findings

Day to day leadership at the home was provided by the registered manager, who provided visible leadership, and was very experienced and 'hands on'. Support with nursing care was provided by a registered nurse who was the clinical need and the deputy manager , and both led by example.
The registered manager explained that people needing nursing and residential care were mixed in all areas of the home. They said, " "I like my nurses to know all my residents."

The culture of the home was open and friendly. People, relatives, staff and visiting professionals all described a "family" atmosphere. The registered manager descried their leadership style as not asking their staff to do anything they wouldn't do. They said they loved to get feedback and constructive criticism and suggestions from staff and visitors.

One person said, "They are all able as a team we are very well looked after." A relative said, "The manager has her finger on the pulse. She always knows how (name of person) is." A visiting professional said, "I am particularly impressed by the stable and consistent leadership provided by (the registered manager) who has a deep understanding of her residents' needs." An agency nurse said, "This is one of my favourite homes, the home is well run and the manager is really good."

Staff said they felt valued for the work they did, were treated fairly and felt well supported. One staff said, "There is nothing I would change". The registered manager promoted leadership and succession planning, and several staff were undertaking leadership and management development training. They had delegated lead roles to senior staff to gain experience and said, "The staff work with the nurses so we get a skill mix and they are learning."

Each day, a staff handover meeting was held to communicate any changes in people's health or care needs to staff coming on duty. The staff team worked on the upper or ground floor and had a list of duties they needed to complete. A staff handover book was used to capture any important information or changes about each person. A communication book was used to pass on messages and reminders between staff, such as about appointments, and changes in people's prescriptions.

Staff were consulted and involved in decision making about the home. The registered manager held regular staff meetings and minutes showed a variety of issues had been discussed, including staff uniforms, duties and use of social media. Staff meeting minutes also showed issues raised by people were discussed with staff so that lessons could be learned from people's experiences..

The provider had a broad range of quality monitoring systems in use which were used to continually review and improve the service. The registered manager did a monthly audit which included local audits of care records, meals and nutrition, staff training, health and safety and infection control. They also did unannounced night visits to meet with night staff and check on people's care. Monthly reports were sent to the provider including reports on accidents and incidents, complaints, staff vacancies and sickness absence.

Provider visits were regularly undertaken by the regional manager or quality manager. They met with people and relatives, looked at care records, at how people's nutritional needs and how other risks were managed. Written reports were provided for each visit, with action plans made in response to address any areas highlighted for improvement. For example, to improve the care records system. This showed the service was committed to continuous improvement.

Monthly analysis of any accidents/incidents were carried out to identify trends and themes. The provider notified us appropriately of any important events which the service is required to send us by law.

The registered manager and staff worked in close partnership with other organisations to provide people's care. They said "We liaise with GP's, community mental health nurses, social services and the hospital." In the Provider Information Return (PIR), the registered manager told us about further improvements planned. This related to plans to implement a tool to assess people at risk of dehydration, which was already being used by health professionals in the local area.