Four Seasons (Bamford) Limited

Elm Bank Care Home

Inspection report

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Ratings

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

Overall summary

We visited the home unannounced on the 21 August 2015.

The home was last inspected in August 2013. We found that they were meeting all the regulations we inspected.

Elm Bank Care Home provides accommodation and personal care for up to 43 older people, some of whom were living with dementia. Respite care and a day care service were also provided. The day care service is not regulated by CQC because it is out of scope of the regulations.

There were 39 people living at the home on the day of our inspection. Accommodation was spread over three floors. There were 16 people living on the top floor and a further 11 on the ground floor who had general personal care and support needs. 12 people who had dementia related conditions lived on the middle floor.

A manager had been in post for almost four years. She was registered with CQC in line with legal requirements. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the

Summary of findings

service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The manager stated that they staffed over and above the levels recommended by the provider's staffing tool. We found however, that staffing levels did not always allow staff to deliver a flexible and responsive service. Safe recruitment procedures were followed and staff said that they undertook an induction programme which included shadowing an experienced member of staff.

There were safeguarding policies and procedures in place. Staff were knowledgeable about the actions they would take if abuse was suspected. One relative contacted us prior to our inspection regarding their concerns about certain aspects of care and support at the home. We passed these concerns onto the local authority's safeguarding adults team. The local authority's safeguarding team were also investigating concerns regarding medicines. We cannot report on these at the time of this inspection. CQC will monitor the outcome of the safeguarding investigations and actions the provider takes to keep people safe.

Checks and tests were carried out to ensure that the premises and equipment were safe. However, some of the décor and furnishings were worn and in need of updating. There was an odour of stale urine around the middle floor. In addition, the environment was not supportive of the needs of the people who lived there. We have made a recommendation that the design and decoration of the premises is based on current best practice in relation to the specialist needs of people living with dementia.

We checked medicines management and had concerns with the recording of medicines. Medicines administration records (MARs) contained duplicate entries of medicines and it was not clear whether certain medicines had been administered because staff had not signed against each entry. We have made a recommendation that best practice is followed in relation to medicines recording.

Staff told us that training was provided. They explained that most of the training was e-learning. Some staff told us that more face to face training, especially in dementia care, would be beneficial. We observed that staff did not always know how to effectively communicate and interact with people who lived on the dementia care unit. Following our inspection, the regional manager informed us that further training had been organised.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. These safeguards aim to make sure that people are looked after in a way that does not inappropriately restrict their freedom. The manager had submitted a number of applications to the local authority to deprive people of their liberty in line with legal requirements. We noticed however, that mental capacity assessments and best interests decisions had not always been carried out for all "decision specific" issues. We have made a recommendation that people's records evidence that care and treatment is always given in line with the Mental Capacity Act 2005.

The manager stated that menus were discussed and agreed with people according to their likes and dislikes. We found however, that the menu was repetitive and did not always evidence that people had access to a range of healthy meals and snacks. We have made a recommendation that the provider follows best practice guidelines to ensure that people receive a healthy and nutritious diet.

We observed that care was provided with patience and kindness and people's privacy and dignity were respected. Most people and relatives spoke positively about the service. One relative said, "Very good care home - we went round three or four locally and that was the best."

An activities coordinator was employed to help meet the social needs of people who lived there. The manager stated that the activities coordinator took people out into the local community. The activities coordinator organised arts and crafts and games on the day of our inspection. We saw however, that activities provision for people who lived on the dementia unit was not always appropriate or effective.

A new electronic monitoring system had been introduced. An iPad was located in the foyer of the home. People, relatives, staff, health and social care professionals were able to provide feedback via the iPad.

Summary of findings

This feedback was immediately sent to both the home and regional managers. This enabled the manager and the provider to obtain immediate feedback and insight into the service.

A new deputy manager had been in post for three months. However, no supernumerary hours were allocated to enable him to update care plans, carry out audits and checks and monitor the provision of care on the dementia care unit.

A staffing tool was used to assess staffing levels at the home. The manager told us however, that this tool did not take into account the needs of people who had a dementia related condition.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. These related to staffing levels and governance. The action we have asked the provider to take can be found at the back 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?

Requires improvement

Not all aspects of the service were safe.

Checks and tests were carried out to ensure that the premises and equipment were safe. However, some of the décor and furnishings were worn and in need of updating. There was an odour of stale urine around the middle floor.

We found some concerns with the recording of medicines and have made a recommendation that best practice is followed in relation to medicines recording. The manager stated that they staffed over and above the levels recommended by the provider's staffing tool. We found however that staffing levels did not always allow staff to deliver a flexible and responsive service.

Safe recruitment procedures were followed and staff were knowledgeable about what actions they would take if abuse was suspected.

Is the service effective?

Requires improvement

Not all aspects of the service were effective.

We observed that certain staff were more confident and skilled at communicating with people who lived with dementia than others and not all staff had completed dementia care training.

The manager stated that menus were discussed and agreed with people according to their likes and dislikes. We found however, that the menu was repetitive and did not always evidence that people had access to a range of healthy options for meals and snacks.

Mental capacity assessments had not always been carried out for all “decision specific” issues. In addition, the environment did not support the needs of those who had a dementia related condition.

People were supported to access healthcare services. This demonstrated that individual’s health needs were being considered and met to maintain their wellbeing.

Is the service caring?

Good

The service was caring.

During our inspection, we observed staff were kind and compassionate and treated people with dignity and respect.

Most people and relatives told us that they were involved in people’s care.

Surveys were carried out and meetings were held for relatives and friends.

Is the service responsive?

Requires improvement

Not all aspects of the service were responsive.

Summary of findings

We found that activities provision did not always meet the needs of people who had a dementia related condition.

Care plans were not always specific and it was sometimes difficult to gain an overview of people's needs.

There was a complaints procedure in place. A new electronic monitoring system had been introduced. An iPad was situated in the reception area of the home. This was used to obtain feedback from people, relatives and visiting health professionals

Is the service well-led?

Not all aspects of the service were well led.

We found that an effective system to monitor the quality of the service was not fully in place. While checks and audits were carried out; the concerns we found regarding the care of people who had a dementia related condition had not been highlighted.

A new deputy manager had been in post for three months. However, no supernumerary hours were allocated to enable him to update care plans, carry out audits and checks and monitor the provision of care on the dementia care unit.

A staffing tool was used to assess staffing levels at the home. The manager told us however, that this tool did not take into account the needs of people who had a dementia related condition. She said that this was being addressed.

Requires improvement

Elm Bank Care Home

Detailed findings

Background to this inspection

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

The inspection team consisted of an inspector, an inspection manager, a specialist advisor in dementia care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. We also sought advice from a CQC pharmacy inspector and a nutritional specialist nurse.

We visited the home unannounced on 21 August 2015.

We spoke with the operations director, regional manager, registered manager, deputy manager, five care workers, an activities coordinator and the maintenance man. We looked at five people's care records and two staff recruitment files. We looked at a variety of records which related to the management of the service such as audits, minutes of meetings and surveys.

We spoke with seven people and two relatives on the day of our inspection. Some people were unable to communicate with us verbally due to the nature of their condition. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. Following our inspection, the expert by experience contacted five relatives by phone to ascertain their experiences of the service.

We conferred with a social worker and a reviewing officer from the local NHS Trust. We also consulted a member of staff from the local authority safeguarding team and a local authority contracts officer.

Prior to carrying out the inspection, we reviewed all the information we held about the home. The manager completed a provider information return (PIR). A PIR is a form which asks the provider to give some key information about their service, how it is meeting the five questions and what improvements they plan to make.

Requires improvement

Is the service safe?

Our findings

Prior to our inspection, we received information of concern about staffing levels at the home. We took this information into account when planning our inspection.

The manager stated that they staffed over and above the levels recommended by the provider's staffing tool. She told us there were usually six care workers on duty through the day, with two allocated to each floor. There were seven on duty on the day of our inspection because one care worker was on induction and shadowing an experienced member of staff. There were four staff on duty overnight to look after people. We received mixed comments about whether there were enough staff on duty throughout the day. Some people and staff informed us that more staff would be appreciated. They explained that there were sufficient staff to meet people's physical needs. However, they felt more staff would enable them to deliver more person centred care and provide increased emotional and social support, especially to those with a dementia related condition. They also explained that the layout of the home affected staffing levels since accommodation was spread over three floors.

We observed care and support was carried out in a calm, unhurried manner on the top and ground floors. However, on the middle floor we observed that care and support was more rushed. We spoke with relatives following our inspection. One relative who contacted us prior to the inspection said, "They don't have enough staff, they don't have enough time" and "They are too thin on the ground."

The deputy manager worked on the middle floor with another care worker. We saw that he carried out care duties, completed certain audits and checks, administered medicines and updated care plans. The manager informed us that the deputy manager did not get any supernumerary time. We found shortfalls with the recording of medicines and care plan documentation, especially on the middle floor, and considered that insufficient time was allocated to ensure documentation was comprehensively completed.

The manager informed us that if assistance and support was required on the middle floor, a care worker from the ground floor would be sent, since this floor was generally quieter. This action however, meant that the ground floor would be left with only one member of staff. We considered that this movement brought about disjointed care delivery.

The weather was bright and sunny on the day of our inspection. We did not see staff support people to access the garden or go outside. Staff told us that the activities coordinator organised trips out for small groups of people, but it was sometimes difficult for them to assist, because they were required to stay in the home and support people with their care needs.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 regulations. [Staffing].

We checked medicines management. We looked at people's medicines administration records (MARs) on the top and middle floors. We noted that some contained duplicate medicines entries. In addition, it was not clear whether certain medicines had been administered because staff had not signed against each entry. Staff told us that certain medicines had been discontinued and others were not required. This information was not documented on the MARs. One person self-administered a liquid bowel medicine. We checked the person's room and saw the liquid bowel medicine was stored insecurely on the person's bedside cabinet, together with paracetamol and another bowel medicine. Staff informed us they were unaware that the person had paracetamol or the alternative bowel medicine as the individual went out into the local community independently and purchased various items. We looked at the individual's MAR and noted that he was also prescribed paracetamol once a day at night. This meant that there was a risk that the person could be taking more paracetamol than prescribed.

Following our inspection, the regional manager wrote to us and stated, "Training and audit to be carried out with Care Quality Facilitator, linking in with [name of pharmacy] to ensure duplicates are not sent to the home."

There were safeguarding policies and procedures in place. Staff were knowledgeable about the actions they would take if abuse was suspected. Prior to our inspection, one relative contacted us regarding their concerns about certain aspects of care and support at the home. We passed these concerns onto the local authority's safeguarding adults team. The local authority's safeguarding team were also investigating concerns regarding medicines. We cannot report on these investigations at the time of this inspection. CQC will monitor the outcome of the safeguarding investigations and actions the provider takes to keep people safe.

Requires improvement

Is the service safe?

Checks and tests were carried out to ensure that the premises and equipment were safe. However, some of the décor and furnishings were worn and in need of updating. There was an odour of stale urine around the middle floor. We found several arm and dining type chairs which were engrained with debris at the edges with some stains on the fabric. The housekeeper acknowledged these findings and advised she would take swift action to deep clean these items.

One person, was very unhappy about the cleanliness of her room and the daily input from the domestic team. We checked her room and found her concerns were substantiated, such as failure to empty her waste bins. The housekeeper advised, "We are one down today."

We noticed that the external pathways at the back of the building were covered in green moss which could pose a trip hazard. In addition, the main garden appeared unkempt. We discussed these issues with the manager who told us she would discuss this with the maintenance man who addressed the pathways concern immediately.

Several bedside tables which were in use in people's bedrooms were badly worn and damaged around the edges creating sharp and rough edges which posed a risk of injury and could not be properly cleaned. We also found some badly chipped toilet seats. The operations director gave instructions for these to be replaced straightaway. The manager told us that redecoration and refurbishment of the home was planned and due to start in September 2015.

Risk assessments and care plans were in place to assess people's mobility, nutritional needs, risk of choking and swallowing problems, skin condition and behavioural challenges. We saw that these gave staff information on how they should manage a variety of risks. The manager told us that an investigation was currently being carried out following concerns that correct moving and handling procedures had not been followed for one individual which may have contributed to a fall. We will monitor the outcome of this investigation to ensure that people remain safe.

Staff told us, and records confirmed that relevant checks were carried out before they started work. These included Disclosure and Barring Service checks. In addition, two written references were obtained. These checks were carried out to help make sure that prospective staff were suitable to work with vulnerable people.

We recommend the provider references and follows national best practice guidance in relation to medicines management.

Requires improvement

Is the service effective?

Our findings

Most people and relatives informed us that staff were knowledgeable and met people's needs effectively. One relative who contacted us prior to our inspection felt that more training in dementia care was required.

We spoke with health and social care professionals. One stated, "We've provided training in the past around correct recording of fluids charts and the diabetic nurse and tissue viability nurse have come in to provide training."

Staff told us that there was training available. They explained that most of the training was e-learning. The manager provided us with information on training which showed us that staff had completed courses in safe working practices and most had completed training to meet the specific needs of people who lived at the home; such as dementia care. Some staff told us that more face to face training would be appreciated. In one staff training file we saw that 20 training topics had been covered during one day of induction. Out of a total of 33 training topics covered overall six had been delivered through face to face training.

We observed that certain staff were more confident and skilled at communicating with people who lived with dementia than others. One care worker describes the challenges of working on the middle floor and they sometimes felt ill-equipped to deal with certain behaviours or people' specific needs. We spoke with the operations director, manager and regional manager about our observations. The operations director informed us that further training would be organised.

Following our inspection, the regional manager wrote to us and stated, "88% of staff have completed e-learning dementia awareness training. A schedule is in place [for staff] to enrol on dementia training with Skills network. Dementia team involvement to support with person centred care"

Staff told us they received supervision and they said they felt supported by the manager. Annual appraisals were carried out. We saw however that the deputy manager, who had been in post for three months, had received only one supervision session. This was his first management post and it was not clear whether sufficient support was provided. Supervision and appraisals are used to review staff performance and identify any training or support requirements.

Following our inspection, the regional manager wrote to us and stated that the deputy manager had been allocated supernumerary hours and a programme of guidance and support was in place for him. The manager told us that the deputy manager had completed an in depth induction.

In England, the local authority authorises applications to deprive people of their liberty. The registered manager had submitted a number of DoLS applications to the local authority to authorise in line with legal requirements of the MCA. We noticed however, that mental capacity assessments had not always been carried out for all "decision specific" issues. The regional manager wrote to us after the inspection and stated that further training in this area was going to be organised.

Most people and relatives were happy with the meals provided. The manager stated that menus were discussed and agreed with people according to their likes and dislikes.

Comments from people and relatives included, "She can't swallow now, she is on thickened feeds and they say they have to stand over her to make sure she doesn't choke," "She can't feed herself now - just finger foods and they help her eat. I am very happy with the food" and "My mother is always well fed." One person however, said she had not enjoyed the food and described her dissatisfaction with the choices available. For example, if she did not want fish and chips; the option was a fried egg. One relative who we contacted by phone, expressed concern about her family member's weight loss. We passed this concern to the local authority's safeguarding team.

We spent time with people in each of the three dining rooms. Staff on the top and ground floors were attentive to people's needs and provided discreet support and encouragement. We overheard questions such as, "How do you like you tea?" and "Do you fancy a bacon sandwich?" We observed a member of staff supporting a person to eat their food and this was provided this in a dignified manner. Staff sat next to people, interacting with them in a positive

Requires improvement

Is the service effective?

manner, making comments such as, “Little bit more?” “Do you want a little more?” This meant people were encouraged and supported to access an adequate dietary intake for their needs.

We noticed that people who ate their meals in their bedrooms on the ground floor did not receive their meals on a tray with condiments and a napkin. In addition, vinegar in the dining room was not readily available for people to select with their fish and chips. We discussed this with the manager who told us that she would address this with staff.

There was limited interaction with people at lunch time on the middle floor. Although pictorial menus were available, people were not shown the choice of meals, which meant that people could not see or smell the food. This would be particularly beneficial to people who were living with a dementia related condition.

Staff provided tea, coffee and cold drinks in the morning and afternoon; biscuits and cheese and crackers were also served. We checked the four weekly menus and saw there were two choices at each meal time. Staff explained that if people did not like what was on offer, alternatives would be provided. We noted however, that the menu was repetitive and there was limited evidence of fresh fruit. We spoke with the manager about this issue. She told us that she had just bought some strawberries and fruit was offered as an alternative pudding. The manager explained that their previous full time chef had recently left and they had just recruited a new one.

We sent the menus to a nutritional nurse specialist to be analysed. She completed a report which stated that the menu was repetitive and “Not nutritionally complete. It lacks vital vitamins and minerals from not meeting the national recommendations of five fruit and vegetables.”

Following the inspection the regional manager wrote to us and stated, “I can agree with the fruit – fresh fruit is now available on each tea trolley. Potatoes and two vegetables are served each lunch time. Bananas are available upon request. Bowls of fresh fruit are to be placed daily in each lounge. Fresh fruit use on offer every morning. Food questionnaires are being completed and ongoing so residents have an input into the menus. Following the feedback and resident wishes and choices we will revisit the menu, however the menu is indicative of fresh vegetables and home cooked food.”

We did not plan to look at the adaptation, design and decoration of the premises. However, we identified some concerns with this area during our inspection.

The National Institute for Health and Care Excellence (NICE) states, "Health and social care managers should ensure that built environments are enabling and aid orientation."[NICE, Dementia - Supporting people with dementia and their carers in health and social care, November 2006:18]. We found that not all of the premises were “enabling” and helped aid orientation.

The registered manager told us that people who lived on the middle floor had a dementia related condition. Most of the corridors were painted in the same colour with few discernible features to aid orientation. The Alzheimer’s Society states, “Design changes, such as using contrasting colours around the home, are very useful in making items easier for people with dementia to identify.” We observed that the environment on the middle floor did not always occupy people’s attention. The Thomas Pocklington Trust’s guidance “Design guidance for people with dementia and for people with sight loss” states that the following should be considered, “Placement of ‘interesting features’ along communal paths and corridors and within individual communal rooms, to stimulate interest and promote memory.”

On the ground floor we found that hot and cold indicators on the taps were worn and there was a very small ‘cloakroom’ size wash basin in a respite room en-suite facility. The additional absence of a suitable chair to sit on meant this facility was not adapted to promote and enable recovering and independence after surgery.

We noted that people were supported to access healthcare services. A relative told us, “She [person] wasn't so well the other day and they rang me and said, ‘She doesn't look so well - we are getting the doctor.’ They do what I would do for her.” A health and social care professional stated, “Generally they access health care professionals.” We read that people attended GP appointments and saw that the dentist, dietitian, speech and language therapist, optician and podiatrist visited the home. We read one entry which stated, “Rang GP as [name of person] looking lethargic and requested GP visit – GP came to visit [name of person] and did body checks, has prescribed antibiotics, advised to put

Requires improvement

Is the service effective?

on bed rest and to push fluids." This demonstrated that the expertise of appropriate professional colleagues was available to ensure that the individual needs of the people were being met, to maintain their health.

We recommend the provider ensures records evidence that where people lack capacity to make decisions, care and treatment is provided in line with the Mental Capacity Act 2005.

We recommend the provider follows best practice guidelines to ensure that people have access to a balanced diet that promotes healthy eating.

We recommend the provider considers the design and decoration of the premises and references current best practice in relation to the specialist needs of people living with dementia.

Good

Is the service caring?

Our findings

People and relatives told us that staff were caring. Comments included, “They’re all lovely here,” “They look after us well;” “Very happy with the care she is receiving;” “Happy with her care;” “She always looks clean and she has nice clothes which they put on. The girls seem kind and caring;” “Brilliant - very happy with the care, very happy with everything really;” “Care is very good; I am a staff nurse myself. Her personal care is very good. She is in the worst part of Alzheimer’s at the moment, so she needs a lot of care, but I am very happy with the standards;” “We are very happy with her care and believe me I am the kind of man who would be saying if there was anything wrong;” “My mother is always well dressed and well fed, her clothes are clean and hung up in the wardrobe” and “I can hardly fault it, the staff have been so kind and helpful.” A person who was receiving respite care stressed how obliging and pleasant all of the staff had been during their stay.

We checked an independent review website for care homes. We noticed that nine people identifying themselves as relatives had posted reviews about the home from January 2015 to March 2015. Comments included, “I cannot rate this place high enough. I cannot thank the staff enough for the care they give my grandmother, [name of person] before she passed away. Although she had very bad dementia she loved every minute she spent here, and would love telling me what she had been doing. From the bottom of mine and my family's hearts. Thank you for your love and support you showed my grandmother, and also the love and support you showed to me and my family in the last few weeks of her life” and “Caring and engaging with their residents, this home provides excellent care with a personal touch. The manager and administrator are as actively involved as the carers this is a rarity in many care homes. The staff go about their work with a sense of purpose and appear to always know what is required of them, but they remain warm and engaged with the residents.”

We noticed positive interactions, not only between care workers and people, but also other members of the staff team. We saw the maintenance man talking to one person about her art. She told us, “[Name of maintenance man] draws me pictures and I colour them in, he’s so good you know.” The housekeeper told us people enjoyed a lie in. She added, “We have no problem with that, they get up when they want.” At lunch time the cook helped to serve out the meals on the top floor. She talked to people throughout the meal time. One person said, “That’s [name of cook] she’s a very good cook and lovely.” There was much laughter at lunch time when one person showed us how she was able to touch her toes and do high kicks. The cook and care workers told the person how amazing she was and said that they wished they were able to do that!

We observed that some staff were more confident and skilled at communicating with people who had dementia related conditions. We considered that this was a training and support issue rather than a shortfall in their caring nature.

We found that people’s privacy was promoted by staff. We saw they knocked on people's bedroom doors before they entered. We observed care staff assist people when required and care interventions were discreet when they needed to be. We read the most recent unannounced “night check visit report” which was carried out by the manager and regional manager on 7 August 2015 at 4am. The manager had recorded, “When buzzers sounded, staff witnessed knocking on doors before going in.”

Most people and relatives informed us that they were involved in care planning and were asked for their views and opinions about the care provided. Comments included, “We get told if anything is wrong and we were involved in all the care planning. We couldn't be happier,” “We get asked to reviews from time to time. We are very happy with her care,” “They consult me about everything. They always ring me if anything amiss” and “I am told immediately if anything is wrong. I was involved in her care planning; where possible it’s mothers own choice.” One relative told us however, “I don't like to complain but if they told you more it would be better.”

Requires improvement

Is the service responsive?

Our findings

Most people and relatives said that staff were responsive to people's needs. Comments included, "I always see the staff when I am there. I have no concerns she seems to be doing very well there," "It's brilliant, I can't praise them enough. [Name of relative's] dementia was getting really bad, she was so withdrawn, but within three weeks of being there they had her knitting again and she hadn't done that in years. She looks so much better in herself, much more talkative .She says 'They look after me, they are nice to me.'" However, one relative who contacted us prior to the inspection raised concerns about the provision of activities at the home.

An activities coordinator was employed to help meet the social needs of people who lived there. She had organised arts and crafts and games on the day of our inspection. One person told us how she loved to paint. She enjoyed colouring pictures which the maintenance man drew for her. She showed us her most recent picture of a stone curlew. The manager stated that people went out with the activities coordinator into the local community.

We spent time observing staff practices on the middle floor. The activities coordinator had organised a game of skittles, dominoes and quoits. People appeared disinterested in these activities and the coordinator often had to play the games herself because people were not able to understand what they needed to do. One person said, "I'm too old for those silly games." One relative who contacted us prior to the inspection told us, "The activities aren't suitable, more thought needs to be put in." We observed how most people remained in their rooms on the ground floor with only two taking breakfast in the dining room. In addition, no one used the pleasant communal lounge. No activities were provided during our time on this floor.

We recognised that staffing levels impacted on the time available for staff to provide flexible and responsive care.

Following our inspection, the regional manager wrote to us and stated, "Residents enjoy sing-alongs, skittles, pet therapy and pamper days, now enjoying doll therapy. Links made [name of local NHS Trust's training department] regarding training. PAL's [activities coordinator] to link in with other dementia homes and PAL's, as well as training in line with Jackie Pool's ethos in relation to activities." Jackie Pool Associates is a specialist dementia care organisation who has developed dementia care systems and training materials for the Health and Social Care sector.

We checked people's care plans. Comprehensive and clear records were in place for a person who was receiving respite care. However, we found it was sometimes difficult to gain an overview of people's needs for those who lived on the middle floor. Care plans were not always specific and did not give staff sufficient guidance on how to support people. We read one communication care plan which stated, "Ensure [name of person] is communicated to at their preferred pace. [Name of person] can reply to simple yes/no questions, staff need to give [Name of Person] plenty of time to process the question and reply." We considered that care plans were not specific and individualised to people's needs, which meant that staff may not provide flexible and responsive care.

We noted that care plans documented the number of baths and showers that people had. We read one care plan review which stated, "7 showers and 1 bath." A member of staff said, "They are done twice a week" [have a shower or bath]. The member of staff showed us a bath list which was stuck to the back of a bathroom door. Staff recorded the initials of those who had received a bath or shower and the temperature of the water. We considered that this approach did not fully demonstrate that a responsive and individualised service was provided in relation to personal care.

We observed a meeting with the manager, deputy manager and a district nurse. The manager told us that these meetings were carried out twice weekly and it gave them the opportunity to discuss people who required palliative care support, speech and language therapy involvement, wound care and any concerns such as infections. We heard them discussing one particular person's care. The individual's pain relief, antibiotic therapy, nutritional supplements and diet were discussed. The district nurse said, "I'm going to have a discussion with the GP and arrange for daily reviews. The staff are to use diet charts and we'll look at this daily; two hourly pressure area care and you contact us and the GP if things worsen." The district nurse told us, "Since the two weekly meetings, things have vastly improved" and "There's nobody with pressures sores at the moment, they have been good at reporting to us."

Requires improvement

Is the service responsive?

A complaints procedure was in place. A record was kept of complaints and information was available to document what action had been taken to address and resolve the concerns which had been raised. There was one ongoing complaint which the provider was dealing with.

"Residents' and relatives' meetings" were undertaken. We read the minutes from the last 'Residents' meeting' which was held on 1 June 2015. Laundry and planned entertainment was discussed.

A new electronic monitoring system had been introduced. An iPad was situated in the reception area of the home. This was used to obtain feedback from people, relatives and visiting health professionals. The iPad had a touch-screen questionnaire and space for additional comments. This information was transmitted in real time to the manager, regional manager and provider's representatives, so they could quickly find and fix any care issues or consider any suggestions for improvements.

Requires improvement

Is the service well-led?

Our findings

We did not have any concerns about the care provided on the top and ground floors. However, we did not have such a positive experience on the middle floor, where people with a dementia related condition lived. We found that the environment did not fully meet the needs of people who lived there. In addition, some staff were more skilled and confident in communicating with people than others. We asked the manager and deputy manager whether they were happy with the accommodation for people who had a dementia condition. Both said no and felt that further improvements were required with the environment.

Whilst checks and audits were carried out on all aspects of the service; the concerns we found regarding the care of people who had a dementia related condition had not been highlighted. We spoke with the regional manager about this issue. She told us that Elm Bank had not intended to have a specific unit for people who required this level of support. She said the unit had evolved because more and more people who had these types of need had moved into the home. She said that this was why full consideration had not been given to the environment or staff training, since people had previously had more general personal care and support needs.

A new deputy manager had been in post for three months. The manager told us that his previous experience in dementia care made him an excellent appointment. We found however, that no supernumerary hours were allocated to enable him to update care plans, carry out audits and checks and monitor the provision of care. Although the deputy manager was assigned to the middle floor, he was relatively new and this was his first management post. We considered that the manager's own oversight of the care for people with a dementia related condition was not clear and should be reviewed.

A staffing tool was used to assess staffing levels at the home. The manager told us however, that this tool did not take into account the needs of people who had a dementia related condition. We spoke with the regional manager about this issue. She said that they were addressing this and were going to amend the tool to ensure that it correctly assessed staffing levels based upon the dependency levels and needs of all people who lived at the home.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. [Good governance.]

Following our inspection, the regional manager wrote to us to explain their plans for the ongoing management of the service. She stated, "The first plan is for the environment to be correct, then ongoing training and support. Audits and monitoring systems are in place for the whole home, specific audits for quality dining, audit of activities and care plans will be introduced to the middle floor to evidence effectiveness for the residents who live there. Regular meetings with relatives and residents to see how they enjoy living in the home, name changes for different floors within the home as not to be addressed as middle floor or dementia floor."

There was a registered manager in place. She had been in post for nearly four years and was registered with CQC in line with legal requirements. She held management, care and training qualifications. Staff spoke positively about her. One staff member said, "She's very approachable, I can go to her anytime." Another stated, "She's always around and comes out on the floor to check we're alright." Most people, staff and relatives also spoke positively about the manager. Comments included, "The manager was very good and helped put my mind at rest about her going in" and "The manager was very helpful, Staff always talk to you when you go in." One relative who contacted us prior to the inspection considered that the home was not well led because of the concerns with staffing and the provision of care for people who had a dementia related condition. Another felt the manager could have been more visible and accessible.

Staff informed us that morale was good and they enjoyed working at the home. Comments included, "I love my job" and "Working here gives me so much more job satisfaction, knowing that I'm helping people." This was confirmed by our observations of staff at the home, who carried out their duties cheerfully.

A "Thematic resident and care audit" [TRaCA] had been introduced. The manager explained that this was used to check people's care and other aspects of the service such as health and safety, governance, housekeeping and human resources. She explained that she used an iPad to complete these audits and since the iPad was portable, she was not confined to the office and was able to carry out these audits with people and staff in all areas of the home.

Requires improvement

Is the service well-led?

The manager told us, and records confirmed that "Flash meetings" took place daily. These were attended by the heads of each department including; the manager, deputy manager, maintenance man, cook and housekeeper. The focus of these meetings was to discuss any issues or concerns about people's care and the home in general. Feedback from these meetings was passed to staff on each floor. The manager also carried out "walk arounds" of the home each day and spoke with people and staff.

Staff meetings were held. Staff informed us that they could raise any issues and said that their opinions were listened to and acted upon. We read the minutes from the latest senior care workers meeting which was held in July 2015. Record keeping, safeguarding, DoLS and infection control were discussed. The manager ended the meeting by thanking staff "for being such a great team and for their commitment and hard work."

Unannounced night time checks were carried out. We read the latest report which was carried out at 4am on 7 August 2014 by the manager and regional manager. These were carried out to make sure people where receiving appropriate care and support. The report recorded that people using the service were checked and there were no concerns. The manager had recorded, "All [people] appeared well rested and comfortable." Staff were carrying out their duties as expected and records relating to people's care and support needs were being updated as required.

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 The provider did not have an effective system in place to assess, monitor the quality and safety of the service. Regulation 17 (1)(2)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not sufficient staff deployed to ensure the welfare of people who lived at the home. Regulation 18 (1).