HC-One Oval Limited

Pinehurst Care Home

Inspection report

Pinehurst
Sevenoaks
Kent
TN14 5AQ

Tel: 01732762871

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Pinehurst is a nursing care home registered to provide accommodation and personal care for a maximum of 30 people. The home specialises in providing care to older people, people who are frail and some people living with dementia. At the time of our inspection there were 28 people living in the service. Pinehurst is located in Sevenoaks and is arranged over one floor.

Pinehurst is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was a registered manager at the service. 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 were protected from abuse. Staff knew how to access the safeguarding policy, and were clear about their responsibilities if they needed to report any concerns. The registered manager was clear about the procedures when reporting concerns. Risks to people were assessed and minimised. Risks to the environment were managed in order to keep people safe. There were enough staff to meet the needs of the people using the service. Staff were recruited in a safe manner. People received their medicines safely. People were protected by the prevention and control of infection. The service held a policy on infection control and practice that followed Department of Health guidelines and helped minimise risk from infection. Accidents and incidents were reported by staff in line with the provider's policy. The registered manager investigated any concerns, and changes to care and support were communicated to staff.

The premises did not meet the needs of people living there, particularly for those with dementia. We made a recommendation about this. Staff received the training they needed to carry out their roles effectively. People's needs were assessed and their care was delivered in line with current legislation. People were supported to eat and drink enough to maintain a balanced diet. Staff worked together across organisations to help deliver effective care when people move between services. Staff were knowledgeable about the Mental capacity Act, knew how to seek consent for care and knew the processes to help those who lacked capacity make decisions. People were helped to make decisions about their care.

People were treated with kindness, respect and compassion. Staff supported people to express their views and be actively involved in making decisions about their care. People's privacy, dignity and independence was promoted. People were assisted discreetly with their personal care needs.

People received personalised care that was responsive to their needs. Most people were supported to follow their interests and take part in activities that were appropriate to them, but staff felt more could be done for people living with dementia. We made a recommendation about this. People were encouraged to

maintain relationships with those who matter to them. Family members and friends were welcomed into the service. Complaints were listened and responded to. People told us they knew how to make a complaint and were confident to do so if they needed to. People were supported at the end of their life to have a comfortable, dignified and pain free death.

There was an open and inclusive culture at the service. Staff we spoke to described how they felt proud about the work they did, and how they worked well as a team. Management encouraged transparency and honesty within the service. The registered manager understood the legal requirements of their role. People, their families and staff were encouraged to be engaged and involved with the service through meetings and on-going feedback to management. There were strong links with the local community.

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

Pinehurst was safe.

People were protected from abuse.

Risks to people were assessed and minimised.

There were enough staff to meet the needs of people.

Staff were recruited in a safe manner.

People received their medicines safely.

People were protected by the prevention and control of infection.

Accidents and incidents were reported by staff in line with the provider's policy.

Is the service effective?

Requires Improvement

Pinehurst was not always effective.

The premises did not always meet the needs of people living there.

Staff received the training they needed to carry out their roles effectively.

People's needs were assessed and their care was delivered in line with current legislation.

People were supported to eat and drink enough to maintain a balanced diet.

Staff worked together across organisations to help deliver effective care when people move between services.

Staff were knowledgeable about the Mental capacity Act, knew how to seek consent for care and knew the processes to help those who lacked capacity make decisions.

Is the service caring?

Good

Pinehurst was caring.

People were treated with kindness, respect and compassion.

Staff supported people to express their views and be actively involved in making decisions about their care.

People's privacy, dignity and independence was promoted.

Is the service responsive?

Good

Pinehurst was responsive.

People received personalised care that was responsive to their needs.

Most people were supported to follow their interests and take part in activities that were appropriate to them.

People were encouraged to maintain relationships with those who matter to them.

People knew how to make a complaint and were confident to do so if they needed to.

People were supported at the end of their life to have a comfortable, dignified and pain free death.

Is the service well-led?

Good

Pinehurst was well-led.

There was an open and inclusive culture at the service.

Management encouraged transparency and honesty within the service.

People, their families and staff were encouraged to be engaged and involved with the service through meetings and on-going feedback to management.

There were strong links with the local community.

Pinehurst 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.

This inspection took place on 24 and 25 January 2018 and was unannounced. It included direct observation of care and support, interviews with people, their relatives and staff employed by the service, and review of care records and policies and procedures.

Before the inspection we looked at information we held about the provider. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We looked at previous inspection reports and notifications we had received. Notifications are information we receive from the service when significant events happen, like a serious injury.

The inspection team consisted of two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. We spoke with the registered manager, the clinical services manager, one senior carer, three care staff, one registered nurse, five people living at Pinehurst and four people's relatives. We looked at five people's care plans and the associated risk assessments and guidance. We looked at a range of other records including four staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys and audits.

This was the first inspection of Pinehurst Care Home since a change to the provider in December 2017.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe living at the service. One person told us, "In here I have no concerns or worries I feel safe, the staff look after me very well. I would speak to the manager if something wasn't." Another said, "Yes I feel safe here, there's always someone about if I need help." A relative told us, "The building is secure. If my husband goes wandering he cannot get out. He has settled in surprisingly well, has not asked to come home. I feel he is safe here."

People were protected from abuse. Staff knew how to access the safeguarding policy, and were clear about their responsibilities if they needed to report any concerns. Staff were trained on how to identify abuse during their initial induction and had refresher training each year. The registered manager told us, "Myself and my deputy observe staff to make sure what they have learnt is being put into practice." Management made sure any changes to legislation, or learning from incidents were shared with staff through team meetings. People who used the service were aware of what keeping safe meant. Staff discussed with them about what was acceptable behaviour when they moved into the service, and one person told us, "I often tell people I feel safe and happy here." The registered manager was clear about the procedures when reporting concerns to the local authority and our records showed the manager had notified the Care Quality Commission of any concerns appropriately. People were protected from discrimination. During the initial assessment, people's protected characteristics, such as their race, religion and disability were recorded, and staff were trained in equality and diversity during their induction. People's sexuality was not being specifically identified during their initial assessment. We spoke to the registered manager about this, and they said they were due to start using the incoming provider's assessment forms shortly, which would identify all the protected characteristics of the people they supported.

Risks to people were assessed and minimised. Staff carried out risk assessments about people when they moved into the service, covering areas of need such as risks to moving and handling, falls, and skin integrity. People were encouraged to take part in the risk assessment process. For example, one person was at risk of falling out of bed at night. Records showed that discussions were held between the person, their family and staff, and the person decided they did not want bed rails to be put on their bed. Staff arranged for a mat providing protection to be put on the floor next to the bed instead. Another relative told us, "My wife is in danger of falling over when she tries to walk. The home has provided pressure mats attached to an alarm just in front of her chair in the lounge and her room. If she tries to stand up the staff are immediately alerted." Risk assessments were regularly reviewed and information about changes to risk were exchanged verbally by staff at handover meetings. One staff member told us, "It's a small home and we get to know people so well that there's not always a need to look at the risk assessments in the files. But we use a daily handover sheet which means I always know if there have been any changes."

Risks to the environment were managed in order to keep people safe. The service employed a staff member who was responsible for the maintenance of the building and its contents. There were weekly and monthly audits in place to check water systems, air conditioning, the call system used by care staff, and kitchen equipment. Fire safety equipment was checked, and the service carried out yearly fire evacuation drills, which included staff and people living at the service. Observation reports were completed which highlighted

how many staff had attended, the time it had occurred and any issues identified, such as staff not taking evacuation aids with them. Further action such as reminding staff of the importance of taking the evacuation aids with them was also documented. Where areas of concern were identified in audits, remedial action was taken. For example, a fire risk assessment was carried out in June 2017. There were some actions to be completed such as the electrical intake cupboard had no fire resistant doors and external primary lighting required. Records showed all actions had been rectified. Manual handling equipment such as bath lifts and hoists were serviced every six months, and checks were made on equipment people brought into the home themselves such as wheelchairs or recliner chairs. Information about servicing schedules and contractors had been passed between the previous and new providers of the service. The person responsible for maintenance told us, "I've not come up against any problems with them sharing information yet. For example, the fire extinguishers were due for their bi-annual service. The new provider arranged for the service without him needing to be prompted. When the dishwasher broke down, the new provider's helpdesk had all the relevant information in order for it to be fixed". Relatives were complementary about how well maintained the building was. One person told us, "The home is extremely impressive. It has been here for a few years now, the maintenance and décor is still immaculate. It's well maintained."

There were enough staff to meet the needs of the people using the service. The registered manager told us they used a dependency tool to determine the numbers of staff required based upon the needs of the people living there. Care staff were organised into three teams covering three areas of the home, with each area having two care staff and one senior supporting ten people. Two nurses were deployed to ensure people received their medicines in a timely manner. On the day of inspection we observed sufficient staffing was available to meet the needs of people. Feedback from people using the service about staffing levels was positive. One person told us, "Staff are very attentive. They help me when I have a bath and stay with me while I wash myself." A relative said, "Staffing levels here are pretty good, knowing all the issues care homes are having finding staff." The registered manager told us there were longstanding problems with recruitment of care staff which they were in the process of addressing, such as with improved advertising. The new provider was carrying out a 'hotspot' review of pay and conditions at other local homes and would use the intelligence gathered to help improve recruitment. The service had access to agency staff, and these were only deployed when they worked together with a permanent member of staff.

Staff were recruited in a safe manner. Pre- employment checks, including checks with the Nursing and Midwifery Council for nursing staff, were made. Staff completed Disclosure and Baring Service checks to ensure that they were safe to work at the home. The Disclosure and Barring Service helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. References were sought and checked. However, in two of the files we looked at there were gaps in employment history that were not thoroughly explained. We spoke to the registered manager about our concerns, who told us that they would carry out an immediate review of all staff files and ensure any gaps in employment history were explained and recorded. Following our inspection the registered manager confirmed all files were up to date and accurate. Each new member of staff was required to take part in an induction before working with people independently.

People received their medicines safely. When people moved into the service their ability to manage their own medicines was assessed and recorded in their care file. When required, people were supported with their medicines by a registered nurse or a senior carer. The role of supporting people with their medicines was new to the seniors, and they told us they felt confident to support people safely. One senior told us, "I had three days training to be a senior carer. Then I took additional online training on medication. I watched the nurses carry out their medicine rounds, and then when it was my turn to start helping people the nurses would watch me. I can go to the nurses if I ever had a problem." A registered nurse said, "I think the seniors are so good at doing the medicines. They are enthusiastic and they take the responsibility seriously." Most

people's medicines were dispensed from blister packs provided directly from the local pharmacy. If people needed 'as and when' medication such as paracetamol, these were stored safely and details were recorded accurately in the medication records. The records had photographs of the people being supported which helped reduce the risk of mistakes. Medicines were stored safely. The nurse in charge used a locked medicine trolley, and all medicines were kept in a locked room. The room and fridge temperatures were monitored to ensure medicines were kept at the correct temperature. Medicines were given to people in line with the Mental Capacity Act 2005. Staff supporting people with medicines were knowledgeable about the Act and implemented the principles in their role. The registered nurse had identified someone who was chewing their medication rather than swallowing it as intended. The nurse thought it might be more appropriate to have the medicine crushed up in food, but they were assessed as lacking the capacity to consent to this. At the time of the inspection the nurse was waiting for a best interest meeting to take place, including input from the GP and family members. The service had close relationships with two local GPs who visited on a weekly basis, or as and when needed. Records showed medication reviews took place appropriately. When moving between services, such as when people went into hospital or when people left the service following a respite stay, the registered nurse provided them with a photocopy of their medication records to ensure other professionals had up-to-date information about their medication.

People were protected by the prevention and control of infection. The service held a policy on infection control and practice that followed Department of Health guidelines and helped minimise risk from infection. Staff had access to personal protective equipment (PPE) such as aprons and gloves and alcohol gels were seen throughout the building. The service was clean and hygienic during our inspection. Different coloured aprons were used for the meal service or when providing care. Linen bags were coloured so staff knew if they contained clean or soiled linen. Staff were aware of the infection control policy, and they received training during their induction with yearly updates afterwards. The registered manager monitored staff practice through regular competency checks carried out as part of the overall quality assurance audits.

Accidents and incidents were reported by staff in line with the provider's policy. The registered manager investigated any concerns and changes to care and support were communicated to staff. For example, a number of falls relating to the same person were reported by staff. The registered manager asked staff to keep a log of the falls, and the person's risk assessment and care plan were reviewed. This identified the person was sometimes leaving their walking frame behind when getting up to walk. The care plan was amended to reduce the risk, and information as shared with staff via the daily handover and in team meetings.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us their needs were met and staff were skilled in carrying out their roles. One person said, "I am unsteady on my legs and don't like getting up without someone with me. The staff have moved my armchair sideways for me so that I can now see out the window to the garden and also see them passing the door." A relative told us, "Watching the different ways staff talk to and help people show that they know the different needs of the residents."

People's needs were not always met by the adaptation, design and decoration of the premises. People were encouraged to choose how their rooms were decorated and could bring in their own furniture from home to help them feel more comfortable. However, it was acknowledged by the registered manager that the décor and signage of the home had not been always designed with the needs of people with dementia in mind. The carpet was patterned and the communal walls were painted a beige colour which might make it difficult for some people to find their way around the building independently. Bedroom doors were numbered but some people did not always know where their bedroom was. One staff member told us, "We have to keep the balcony doors shut because [resident] will walk into rooms that aren't hers and she will try to get out." We spoke to the registered manager about our concerns and we were told they have asked the new provider for a renovation or parts of the building.

We recommend the registered provider seeks guidance from a reputable source in the development of a dementia friendly environment.

Staff had the training and skills they needed to meet people's needs. An induction training portfolio was given to each new staff member to complete when they started working at the service. The booklet was a pathway for the Care Certificate framework which included a five day classroom-based training programme. The Care Certificate is designed for new and existing staff and sets out the learning outcomes, competencies and standard of care that care homes are expected to uphold. This programme covered fire safety, health and safety, infection control, the Mental Capacity Act and DoLS and challenging behaviour. The third day consisted of observations and shadowing in the home. The induction was signed off by trainer and the new employee when completed. Staff told us they thought the induction prepared them for their role. Staff had received essential training which included nutrition and hydration, behaviour that challenges, Mental Capacity Act and DoLS, food safety, medicines awareness and safeguarding. After training was provided competency assessments were carried out with nurses and senior carers. This was done partly as self- study and some observations were carried out by the clinical services manager. Staff were positive about the quality of the training. However, although training about dementia had been provided to most staff, there were concerns from some staff that it did not equip them with all of the skills they would require to carry out their roles as people's dementia needs increased. One staff member said, "We've had dementia training but I think we could have more. Sometimes things happen and we're not always sure what to do." We spoke to the registered manager about these concerns from staff. Conversations the registered manager held with the incoming provider had confirmed additional training on dementia would be given to all staff. Training on other specific needs of people was provided when required. One person needed to be fed using a percutaneous endoscopic gastrostomy (PEG), which allows nutrition, fluids and/or medications to be put

directly into the stomach and bypassing the mouth. The registered manager arranged for all staff to be trained by an external provider on how to use it. A PEG allows nutrition, fluids and/or medications to be put directly into the stomach and bypassing the mouth. The local hospice provided some training on palliative care.

People's needs were assessed and their care was delivered in line with current legislation. The registered manager told us they were yet to adopt the new provider's assessment documentation, but staff were clear they were to refer to existing processes when assessing new people. In the assessments we saw, each person took part in a pre-admissions assessment before they moved into the service. This assessment took into account their physical and mental health needs, such as eating and drinking, senses, and how they make decisions. People's social needs were assessed, recording details about their family relationships and activities they liked to take part in. People's relatives were invited to the assessments if the person wished, and the registered manager told us how they would refer to external advocacy if the person wanted support. People's protected characteristics such as their religion and disability were recorded. Care was delivered taking preferences into account. For example, people were asked if they would prefer to be supported by a male or female member of staff, and the rota showed both male and female staff were on shift each day. One staff member told us, "Just because people are here doesn't mean their disability should stop them being independent." Staff received training on discrimination during their induction.

People were supported to eat and drink enough to maintain a balanced diet. One person told us, "The food is excellent, a very good variety. They always offer fresh fruit or yoghurt instead of steamed pudding. When I came here from hospital I was very poorly and not drinking enough. Staff always make sure I am drinking and record it in their files." Another said "I asked the kitchen to puree my food for me and it always looks good. Because I cannot taste anything I asked for tomato ketchup. The kitchen have now given me my own bottle which they will put on my meal if I ask them to." The service was using the previous provider's menu at the time of the inspection, which had been developed by a nutritionist to help ensure it provided a balanced diet to people. A student had recently spent some time at the home as they were studying a course on nutrition in the elderly. The registered manager planned to implement any findings into the menu. The chef visited people each morning to ask what their preferences were for the day, and people were able to choose something off the menu if they wanted to. The chef was also involved in resident and relative meetings to gather feedback. One suggestion was to have 'themed days', where food from different parts of the world was served, such as from America, Spain or Ireland, and this had been implemented. People who had complex needs associated with eating and drinking were supported. The home sought guidance from the local speech and language team, who suggested some people received a soft or pureed diet. Information on people's needs was easily accessible to the chef and kitchen staff. People were complimentary about how pureed food was served. One relative said, "The food wasn't all mixed up like I expected it to be. The chef made sure each item of food was separate on the plate. It looked like restaurant food." Where there were concerns about people's weight, the service sought advice from the dietician. During our inspection we observed lunch, which was relaxed and sociable with people chatting to each other. People who needed assistance were offered help to eat their meals. Staff would sit down beside them ensuring they were at eye level with the person. One staff member sitting with one person encouraged the person to feed themselves and offered to sit with them to assist as needed. The staff member sat chatting with the person throughout their meal. People were able to have meals in their bedrooms if they chose to. People had access to hot and cold drinks and snacks at all times of the day. People in their rooms had a thermos of cold water which was replaced daily which enabled them to help themselves. Staff ensured that they offered drinks regularly to people who were unable to help themselves. Several people had beakers with a straw to enable them to continue drinking independently without spilling the contents.

Staff worked together across organisations to help deliver effective care when people moved between

services. The care plans we reviewed showed information from the local authority, GP and continuing health care professionals was obtained to ensure the person's needs and wishes were fully known and included. The service sometimes accepted people for respite care. One person needed a course of antibiotics when at the service. The registered manager ensured the information was shared with the person's GP and others when they returned home.

People were supported to have access to healthcare services. One person said, "Staff come with me for my hospital appointments when my family cannot. This is reassuring for me." The registered manager arranged for regular visits from a chiropodist and physiotherapist. One person said, "I have a visit from the physiotherapists once a week and with my exercises I now am beginning to get more movement in my legs." An audiologist visited to clean people's hearing aids and replace batteries. The manager would arrange for a visiting dentist if people did not have their own already. When people were seen by the GP, the registered nurse would return to people to explain what people's medicines were for. We saw the nurses and senior carers explaining what medication was and what it was for when administering medicines to people. People were able to access medical treatment in a timely manner. One relative told us, "One of the staff noticed a rash on father's chest at bath time, they notified the nurse who then asked the doctor to call and give him a proper check. Medication was started straight away."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff were knowledgeable about the Mental Capacity Act, knew how to seek consent for care and knew the processes to help those who lacked capacity make decisions. People were helped to make decisions about their care. One staff member told us, "We have training in the Mental Capacity Act, and the senior staff are very knowledgeable about it if we need to ask anything." When required, formal capacity assessments were carried out and where people lacked capacity for particular decisions, best interest decisions were made involving relevant professionals and family members. One person living with dementia was at risk of injury if they left the building unaccompanied because they had no awareness of the dangers of roads. Following a mental capacity assessment and a conversation with the family, the registered manager referred to the local authority for a best interest meeting so the home could restrict the person from leaving the building by themselves. A DoLS application was made and a plan was put in place to keep the person safe. Staff would ensure the least restrictive practice was used where possible. One person was at risk of falling from their bed, but did not want to use bed rails. The service arranged for special soft mats to be put next to the bed instead, which kept them safe but preserved their dignity and respected their wishes.

Good

Is the service caring?

Our findings

People and their relatives told us they found the care staff caring and treated them kindly. One person said, "They are very caring and conscientious. I get on very well with them. We often have a laugh and joke when they are helping me." Another said, "All the staff are very kind to me, always smiling, they wave and stop to ask me how I am as they walk past." A relative said, "When I go home my husband walks me to the door. One of the staff comes with us and as I leave they distract him and suggest a walk so he doesn't get upset."

People were treated with kindness, respect and compassion. During our inspection we watched how people and staff interacted with each other. There was a homely feel to the service and there were frequent, friendly and humorous interactions between staff and people and their visitors. The registered manager told us, "It's about the culture. It's ok for staff to sit at the end of the bed with someone and have a chat. Sometimes staff will sit and have their lunch with the residents." Staff anticipated people's needs and would go directly to them and ask what they would like to do next. One person wanted to walk; a staff member accompanied them around the building providing a reassuring arm around their back whilst they chatted. We observed staff moving another person around the home in a wheelchair. The staff member said "You might feel a bit of a bump" to let the person know that there was going to be a change in the carpet when they went through a doorway. We observed another staff member talking to a person about visiting their son's house for lunch at the weekend. Initially the person did not remember going out for lunch. However, the carer used orientation prompts to help the person remember and said things like "It was a really cold day", "We had to go and get some big socks for you" and "His house is on a big road". The person then remembered that they had been for lunch and began to talk about it with the care staff. Staff knew the people they supported well. Details of people's life histories and relationships were recorded in their care plans. One person was anxiously talking about a visit from a family member. Staff were able to reassure them by talking about the person's family, where they lived and conversations they had had in the past. One person had a visual impairment. The person's care plan indicated staff should knock on the door before entering as they did for all people, but also announce their name so the person knew who they were.

Staff supported people to express their views and be actively involved in making decisions about their care. One person told us, "Before I came out the manager came out to see me in hospital and discussed what care I would need. I have to be hoisted in and out of bed. We discussed having a physiotherapist each week to help me to get some movement in my legs." Another said, "I have a care plan which changes depending if I need help. I like to do as much as I can for myself staff know that I decide what help I need." When people wanted support from their relatives or friends this was arranged by staff so they were able to fully understand their care. A relative told us, "The manager discussed the care plan with me and my step daughter. We talked about his likes and dislikes, sleeping habits, how he liked to have things done, his medication routine what he liked eating." The registered manager knew how to arrange support for people from external advocacy services if needed but at the time of the inspection everybody living at the service had support from family members. Staff made sure people and their families had access to external organisations which could provide them with advice. Healthwatch had been invited to speak at a recent resident and relatives meeting. The service had access to a financial administrator who supported people to apply for benefits such as attendance allowance. The registered manager was in discussions with a local

funeral director about visiting the home to speak about funeral plans. Each person had been encouraged to register to vote and staff had supported people to the polling station at recent elections.

People's privacy, dignity and independence was promoted. People were assisted discreetly with their personal care needs, staff closed bedroom doors and curtains when helping people with personal care, and each door had a 'do not disturb' sign which staff used. A senior staff member told us, "I don't want people to look like they live in a care home. Dignity is really important. The carers know I'm funny about facial hair and nails, and I want people to be dressed like they did at home." We observed one staff member discreetly close a bedroom door when they noticed a person was getting out of their bed. People and relatives told us that staff treated their family members with respect and ensured that their privacy and dignity was maintained. One person told us, "Today my daughter and vicar came to share communion with me. The staff closed the door and made sure we were not disturbed." A relative said, "He always likes to look smart. Once he had his shirt hanging over his trousers one of the staff quickly tucked it in for him." We observed staff being mindful of not being overheard when speaking about people and their needs. People's relatives told us they were made to feel welcome and could visit at any time they wanted. One relative told us, "When I first came to look around I was told I could come at any time. I think that is a very telling comment, they know what they are doing. I come around at various times day and night and can come in to help my father to eat. Staff always make me feel welcome, they stop and tell me how he is doing, and are always complimentary about him."

Good

Is the service responsive?

Our findings

People we spoke to told us the care and support they received was responsive to their needs. One person told us, "Basically staff are very kind, they always encourage you to do things for yourself." Another said, "I make my own decision on what I want to do. I just wander back and forwards from my room. If I like the activities I'll stay and join in, if I don't I just leave, nobody tries to make me stay". A relative told us, "He likes to wander about using his Zimmer frame, staff don't try to stop him. They walk along with him and chat to him"

People were involved in writing their care plans. We looked at five care plans during our inspection. The plans indicated how people were to be involved in the writing of the plans, any reasons that they would not want to be, and others to be involved such as an advocate or family members. People were encouraged to be independent, in both the planning and delivery of care. One person told us, "We can do what we want to. I'm not so steady on my feet but I still want to get up from the chair on my own. I usually ask one of the staff to be beside me in case I need help." Care plans detailed what the person could do for themselves and the support they needed from staff. People's personal history, preferences and choices were recorded. In one plan we saw a person used to attend church. We spoke to the person who told us, "Today my daughter and vicar came to share communion with me. I can attend the service at the home if I wish."

Most people were supported to follow their interests and take part in activities that were appropriate to them. The service employed a full-time activities coordinator who organised activities based upon interests of people .On the week of the inspection the coordinator had arranged for a talk from the National Trust as this was of particular interest of a number of the residents. The service had ties to two local schools, and students from both visited weekly. The coordinator told us she was originally delivering exercise classes herself but was concerned some of the movements may hurt the residents, so arranged for an external personal trainer to deliver the classes. Following feedback from one person the home was due to celebrate Robert Burns' birthday with haggis tasting. When people were not able to take part in communal activities the coordinator arranged one to one sessions. One person told us, "The activities lady brought me some wool and knitting needles for me to knit some squares for her. I had forgotten how to cast on, the activities person taught me, and I have got the hang of it now. It's good exercise for my fingers."

Most people were complimentary about the activities on offer. One person told us, "The activities always well organised. I like playing scrabble and other games. This afternoon we are doing a crossword. We have been on trips to National Trust places and shopping." However, some staff thought activities for those with dementia could be further developed. One staff member said, "I think some people need more stimulation as activities aren't really geared towards people with dementia. Like sensory activities. I think one person would benefit from having a particular toy." Another said, "The activities are good for some people, but I think we could do more reminiscence work for those with dementia." A senior member of staff said, "We have more people here with dementia now, and I don't think there are enough dementia related activities." We spoke to the registered manager about the concerns raised by staff. She told us that following recent conversations with staff and in order to improve activities for those with dementia, she had asked the activities coordinator to source some specialist dementia friendly equipment for people. The manager had

also engaged with a local arts charity that provide sensory workshops to people with dementia in residential settings, and there were plans for sessions to be held at the service in the near future.

People were encouraged to maintain relationships with those who mattered to them. Family members and friends were welcomed into the service and one staff member told us, "Sometimes it feels like we know the families as well as the residents." Relatives were encouraged to take part in activities and invited on outings. Where people had existing relationships such as with churches, or health professionals like chiropodists or a GP, they were encouraged to continue them when they moved into the service.

Complaints were listened and responded to. People told us they knew how to make a complaint and were confident to do so if they needed to. One person said, "If I have an issue I would speak to the nurse or manager." All staff had received training in how to handle complaints, and the registered manager ensured all complaints were acted upon in accordance with the complaints policy. There had only been one concern raised in the previous twelve months which was from a person who thought that their toiletries had been stolen. With the person's permission, the room had been searched and the toiletries were found. The person was happy with the outcome and the concern was closed. As there were no other concerns or complaints made, there was no analysis carried out. The manager kept a log of all compliments received which had an overview of the compliment received, who it had come from and what action had been taken such as "fed back to staff member". Compliments included "Staff were fantastic". Compliments included thank you cards and comments from service users, their families and visiting professionals.

People were supported at the end of their life to have a comfortable, dignified and pain free death. People were asked about their wishes at the initial assessment if it was appropriate. Staff with hospice experience worked closely with the person, the local hospice, the GP and family members in order to ensure people's decisions and wishes were respected. Staff supported family members and other people using the service when someone died. The registered manager arranged support from the local hospice for those who were bereaved. We spoke to the relative of someone who had recently passed away at the service, who told us, "The nurses were really reassuring. I was staying at the home for five or six hours at a time and they reassured me that I wasn't on my own. I was asking what was going to happen and they told me what to expect. They were kind, gentle and respectful to my mum, and treated her with respect." Staff supported families with arrangements for funerals. There was a policy covering how to lay out a person when they had died. Staff and others living at the service were encouraged to attend so they could say goodbye to the person.

Good

Is the service well-led?

Our findings

People, their relatives and staff told us they thought the service was well led. One person told us, "I get on quite well with the manager. I get all I need from the management and they always listen to my ideas at the residents meetings." A relative said, "The manager is approachable and always makes herself available and takes time to listen." A nurse told us, "Managers come in to the handovers between shifts, and I've not had that anywhere else I've worked before."

There was an open and inclusive culture at the service. The registered manager told us that since the recent change in provider there was more of an emphasis on values but because the change took place only a few weeks prior to the inspection not all the changes had been embedded into the service. The registered manager had attended a number of meetings with the provider, and there had been three site visits from senior staff from the provider. Staff had access to information online. We saw literature and posters around the home that described a culture that focussed on being kind to each other. Staff we spoke to described how they felt proud about the work they did, and how they worked well as a team. One staff member told us, "The staff are all good friends. We're happy together and that's good for the residents." Managers supported fairness within the staff team. The weekly rota was planned fairly, taking staff childcare responsibilities and appointments into consideration. The manager told us, "If you negotiate with people and they see you helping them then they will usually help you too."

Management encouraged transparency and honesty within the service. One staff member said, "There's no bullying here. You feel you can go to anyone and talk to them." Where there were incidents, outcomes of any investigations were shared with families in line with the registered manager's duty of candour responsibilities. The manager said, "If there is a problem I will sit down with the person and their family and say, 'We didn't get it right this time. We will look at it.'" Management had the skills and experience to carry out their role. The manager was a registered nurse, had a health and social care degree. The registered manager understood the legal requirements of their role. They had ensured that all notifications required as per the Health and Social Care Act 2008 had been made to the Care Quality Commission. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support when untoward events occurred. The most recent CQC rating was on display at the service and on the provider's website. This is so that people, visitors and those seeking information about the service can be informed of our judgments.

At the time of the inspection there was not a formal governance framework in place to ensure that quality monitoring was reviewed. The registered manager told us that since the change of provider she had ceased using previous provider's quality assurance auditing tool, but was continuing to monitor the service using the some of the same principles until the new provider's systems were shared with her. However, these audits were not being recorded so we were unable to view any information about how the quality of the service was monitored and assessed in the month prior to the inspection. It was expected that the new framework would be in place in the two weeks following the inspection. Maintenance audits were continuing to take place and being recorded in line with the previous provider's procedure.

People, their families and staff were encouraged to be engaged and involved with the service. There were regular resident and relative meetings. In one recent meeting they discussed the front door not being closed properly, recruitment issues and newly recruited staff who would be joining shortly. The registered manager requested for families to complete feedback and asked for involvement from families in a quarterly newsletter. The meetings also gave people and their relatives the opportunity to feedback on the service and they paid compliments to specific members of staff for individual tasks such as putting up shelves, activities, catering, making Christmas special and a general thank you to all staff. They were also informed about the schedule for upcoming meetings in 2018. One person told us, "The meetings are very good. This year I made a suggestion that we make our Xmas cards and put our address in them so people know who has sent them. The activities lady ran a Xmas card session with us." Staff meetings were held regularly. A meeting with the nurses covered training for nurses on vital signs, feedback from the medication audit, reminder to record fridge temperatures, new PRN form to be used with immediate effect, care staff breaks, a reminder of fire procedures, and a new out of hours number for maintenance of property. Staff were able to input into the meetings and it was recorded "[Staff member] said a special thank you to housekeeping team, for helping with breakfast when we have been short staffed" and "[staff member] suggested we move the residents and relatives board to the dining room to try and encourage more people to read it".

There were strong and growing links with the local community. The registered manager had good relationships with the local authority, hospice, GPs and other health professionals. Staff were proactive in engaging more widely within the community. This included building and maintaining relationships with local schools, churches and people involved in activities such as musicians, personal trainers and other entertainers.