Mr Stephen Castellani

Mont Calm Lydd

Inspection report

Manor House,
Manor Road,
Lydd,
TN29 9HR
Tel: 01797 321127
Website: N/A

Date of inspection visit: 20 and 21 May 2015
Date of publication: 04/09/2015

Ratings

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

Overall summary

The provider has been in receivership since January 2014 and the receivers have a management company acting as their agents and managing this service and others owned by the provider.

We undertook an unannounced inspection of this service on 20 and 21 May 2015. This service provides accommodation and personal care for up to 22 people. People at the home are older people with forms of dementia, some of whom have limited mobility. There were 19 people living at the home at the time of our inspection. Accommodation is arranged over two floors, most people had their own bedroom although one room was shared by two people. Access to the first floor is gained by a lift, making all areas of the home accessible to people.

This service had a registered manager in post. A registered manager is a person who is 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.

Summary of findings

We last inspected the home in March 2014. We found the provider was in breach of regulations about the how they managed medicines and the training provided for staff. The management company sent us an action plan telling us what they intended to do to make the improvements needed. During this inspection we checked to see if the relevant regulations were met. We found our previous concerns had been addressed; however, we identified other areas that breached regulations.

People and their visitors commented positively about the care and support received and their experience at the home. However, the inspection highlighted shortfalls where the regulations were not met. We also identified areas where improvement was required and made recommendations that the home should adopt and put into practice published best practice guidance.

Assessed staffing levels did not ensure that were always sufficient staff to meet people's needs without impacting on their choices about when they got up and went to bed. Staff told us at times their shifts felt difficult and hectic to ensure that people's needs could be met. Some medicines were not correctly stored.

Authorisations made under the Mental Health Act 2005 to deprive people of their liberty were not notified to the Commission when they needed to be.

As a home specialising in the care of people experiencing dementia, we also recommended that they take note of and implement published best practices for adaptations to the home to enhance the safety and experience of people.

When some staff spoke to people, although well intentioned, they on occasion called people "darling" or "duck". For people living with dementia, this practice did not always help people to recognise that staff were talking to them. Most activities tended to be group based and did not take place each day. There was no system to evaluate activities or people's engagement levels in them. Although people and their relatives knew how to make a complaint, no complaints procedure was displayed. The home lacked a plan or strategy of continuous development to ensure that best care practices for a dementia setting were adopted and driven forward. These are areas we have identified for improvement.

The registered manager and deputy manager had a good understanding of the Mental Capacity Act 2005, and Deprivation of Liberty safeguards, they understood in what circumstances a person may need to be referred, and when there was a need for best interest meetings to take place. We found the service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and that people's rights were respected and upheld.

The service records showed that there were low levels of incidents and accidents and these were managed appropriately by staff who sought appropriate action or intervention as needed to keep people safe. Risks were identified and strategies implemented to minimise the level of risk.

Care plans were reviewed regularly and included the views of the people and their relatives or advocates when needed. The home showed an awareness of people's changing needs and sought professional guidance, which was put into practice.

People were able to choose their food at each meal time, snacks and drinks were always available. The food was home-cooked, including some home-made cakes. People told us they enjoyed their meals, describing them as "excellent" and "first class".

Staff understood how to protect people from the risk of abuse and the action they needed to take to alert managers or other stakeholders if necessary if they suspected abuse to ensure people were safe.

Robust recruitment processes were in place. New staff underwent an induction programme and shadowed experienced staff, until they were competent to work on their own. There was a continuous staff training programme, which included courses relevant to the needs of people supported by the home. Most care staff had completed formal qualifications in health and social care or were in the process of studying for these.

The home was led by a registered manager who worked closely with the deputy manager and the staff team. Staff were fully informed about the ethos of the home and its vision and values. They recognised their own roles as important in the whole staff team and there was good team work throughout the inspection. Staff showed respect and valued one another as well as people living at the home.

Summary of findings

We found four breaches in total. Three related to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as well as one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staffing levels were not sufficient to ensure that people's choices, preferences and safety were not impacted upon by staff availability.

Improvements were needed to ensure the safe management of medicines.

The premises and equipment were well maintained with a programme of servicing, maintenance and repair in place.

Robust staff recruitment procedures ensured staff were suitable for their job roles. Staff knew how to recognise and respond to abuse

Accidents, incidents and risks were managed appropriately.

Is the service effective?

Requires Improvement

The service was not always effective.

The adaptation of the home did not reflect best practices to promote and enhance the experiences of people living there.

Staff were provided with opportunities to meet with their supervisor or manager to discuss their work performance, training and development.

New staff received a comprehensive induction and had access to a rolling programme of essential training. Staff were given specific training in the conditions some people lived with in the home.

The service was meeting the requirement of the Deprivation of Liberty safeguards and Mental Capacity Act 2005.

People were supported to access health and medical support.

People enjoyed the food they ate and were consulted about their preferences.

Is the service caring?

Good

The service was caring.

Staff were kind to people. They respected people's privacy and dignity, and maintained their independence.

Staff communicated well with people and their family members, giving them information about any changes.

People's families and friends were able to visit at any time and were made welcome.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Summary of findings

People were not always meaningfully engaged in activities, most activities were group rather than individually based.

People and their relatives knew how to make a complaint although no complaints procedure was displayed.

People and their relatives were involved with their care planning, and the care plans reflected people's individual needs.

Changes in health or social needs were responded to.

Is the service well-led?

Requires Improvement

The home was not always well led.

Quality assurance checks were not always fully effective. Statutory notifications required by CQC were not always submitted. Some policies required updating as they referred to regulations that were no longer current.

As a specialist dementia service, the service did not have an ethos of continual development and improvement, by capitalising on published guidance about dementia care to enhance people's experience of living at the home.

Staff felt supported, but some questioned elements of confidentiality within the management team.

People, relatives and health and social care professionals thought the service was well run and spoke positively about the leadership of the manager.

Mont Calm Lydd

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.

We undertook an unannounced inspection of this service on 20 and 21 May 2015. The inspection was undertaken by one inspector.

We focused on speaking with people who lived in the home, some of whom were able to tell us directly about their day to day experiences. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with staff and visitors. During our inspection we spoke with nine people who live at the home, four visitors, four care staff, the deputy manager and the registered manager as well as a visiting social care professional. Following the inspection, we also sought the views of a health care professional about their views of the home.

We reviewed a range of records. This included four care plans and associated risk information and environmental risk information. We looked at recruitment information for four staff, including some who were more recently appointed; their training and supervision records in addition to the training record for the whole staff team. We viewed records of accidents/incidents, complaints information and records of some equipment, servicing information and maintenance records. We also viewed policies and procedures, medicine records and quality monitoring audits undertaken by the registered manager and management company.

Before the inspection we reviewed the information we held about the service. We considered information which had been shared with us by the local authority, members of the public, relatives and healthcare professionals. We reviewed notifications of incidents and safeguarding documentation that the provider had sent us since our last inspection. A notification is information about important events which the home is required to tell us about by law.

Our last inspection identified breaches of regulations. We looked at the action plan the provider had sent us following the last inspection. This set out how the home intended to make the improvements needed and when they would be completed. This formed part of our planning process for this inspection.

Is the service safe?

Our findings

People who were able to communicate with us told us they felt safe in the home. Their comments included, "I sleep very well here, it feels safe to me" and "I'm just fine living here". To help us understand the experiences of people who didn't communicate with us, we observed their responses to the daily events going on around them, their interaction with each other and with staff. People appeared comfortable and were usually at ease within the home environment. Visitors commented positively, telling us, "The staff all give 110%, it reassures me that my relative is here because I know they are safe". Another visitor we spoke with told us, "I visit very frequently, I have never seen or heard anything here that has given me cause for concern".

Although people told us they felt safe, we found instances concerning the availability of staff and the management of medicines which meant people were not always safe.

The registered manager told us staffing levels were determined according to the dependency levels of people who used the service. In addition to the registered manager and ancillary staff, the staffing at the home consisted of three care staff for the day shift, which started at 8am and finished at 8pm. Two waking night staff supported people from 8pm to 8am. Two people at the home required the support of two staff when they got up and went to bed. In addition, staff told us that another person was particularly active at night. On occasion, this person intermittently occupied one member of staff to ensure that they remained safe and did not trouble other people during the night.

Staffing arrangements meant that the needs of the two people requiring support from two members of staff could only be safely met during the daytime shifts. This was because if attended to by night staff, no other staff were available to meet the needs of other people at the home. Discussion with the registered manager and staff found in practice, one of the two people usually wanted to go to bed by 8pm and their needs and the needs of other people could be met during the transition of staff between shifts. However, the second person normally went to bed after 8pm, this meant that both staff were occupied attending to their needs.

Staff told us and the registered manager acknowledged that at other times of the day, particularly in the mornings before the day shift arrived, work could feel felt hectic. This was because the night staff were attending to the personal care needs of people wanting to get up, making sure that they were safe and not unsupervised in communal areas and providing people who wanted them with drinks. Staffing levels had previously allowed for an extra member of staff from 6am to 8am, however, this practice had ceased with changes of staff.

There were not at all times sufficient numbers of staff to meet the needs of the people living at the home. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection in March 2014 we found concerns about the arrangements in place at the home for the management and administration of medicines. The management company sent us an action plan in May 2014 telling us the changes needed to meet the requirements had been actioned. During this inspection, we found our previous concerns had been addressed. However, we identified different concerns about how some medicines were stored. Some minor improvements were needed in the recording of some medicines.

We assessed the procedures for ordering, receipt, storage, administration, recording and disposal of medicines. Medicines were kept in a securely locked area to which only authorised staff had access. Controlled drugs (CDs) were stored in a locked cabinet which met requirements, but it was not secured to a solid wall with the required 'rag' bolts. (CD cupboards should meet British Standard BS2881:1989 security level 1. See Misuse of Drugs Act 1971).

The storage concerns were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The dose of some people's medicines varied on different days of the week. Where variable dose medicines were given, no system was in place to ensure that the correct amount was administered each time. For example, medicine administration records (MAR) were not countersigned by a second member of staff and no daily pill count took place to reconcile the amount given. While

Is the service safe?

there was no evidence that an error had happened, systems in place did not safeguard against this from happening. This was because there was no system for staff to easily determine if the correct dose was given.

We recommend that the home review and amend their medication policy to ensure practices conform with and reflect best practice in published guidance such as the Royal Pharmaceutical Society for The Handling of Medicines in Social Care or The National Institute for Health and Care Excellence (NICE) Managing Medicines in Care Homes.

Otherwise, good procedures were in place to ensure that the ordering, receipt and booking in of medicines were managed safely; this was the responsibility of deputy manager and head of care. Only trained staff administered medicines and we saw their competency was regularly assessed. Medicine records contained information about people's allergies to ensure they were not given medicines they were allergic to and each medicine administration record included a photograph of the person to ensure staff gave the right medicine to the right person.

Observation found administration of medicines was undertaken appropriately. Staff were patient and knowledgeable, they reminded people what the medicines was and explained if pills were to be chewed or swallowed with a drink. Opened medicines were dated to ensure they were not used beyond their shelf life. Where skin creams were used, charts recorded its application and guidance ensured staff knew where, how much and when the cream should be applied. Refusal of medicine was recorded and contact made with relevant health professionals if this continued. Two people received medicines covertly, best interest meetings had taken place and relatives with a lasting power of attorney were consulted appropriately. When people occasionally needed pain killers or laxatives, the time and quantity given was recorded. We found suitable arrangements were in place for people to have their medicine if they were away from the home.

If people were prescribed antibiotics, staff signed off the line on the MAR charts when the course was completed. Any handwritten amendments to MAR charts or new prescriptions were signed by two members of staff to ensure they had been fully understood and actioned as needed. This helped to safeguard against errors.

Recruitment practices were robust and relevant checks had been completed before new staff started work. Appropriate proof of identity had been obtained and files contained evidence that disclosure and barring service (DBS) checks had been carried out. These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Application forms had been completed and two references had been received in each case. This helped to ensure people were protected by safe recruitment procedures because required processes, underpinned by regular audit checks, had taken place.

Any concerns about people's safety or wellbeing were taken seriously. Discussion with staff showed they understood about keeping people safe from harm and protecting them from abuse. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. There was a policy and procedure that informed them about what to do. The home also held a copy of the locally agreed safeguarding protocols. Staff said in the first instance they would alert any concerns they might have to the registered manager, but understood about and could name the relevant agencies that could be contacted if their concerns were not acted upon.

Staff ensured that people's specific care needs were followed. For example, people with mobility concerns had care plans about how staff should supervise them with walking, any walking aids required or how they should be supported with moving and handling. Where people's skin was at risk of breakdown, suitable pressure relieving equipment was used and the condition of their skin and correct application of creams was closely monitored.

Individual risk assessments were completed and reviewed when needed. Staff were knowledgeable about the people they supported and familiar with risk assessments. These included medication, eating, drinking and risks of skin damage as well as use of equipment such as pressure reducing mattresses, lifting aids and wheelchairs. There was a low occurrence of incidents and accidents, six within the last three months. These were recorded and analysed by the registered manager and used to look for any patterns or trends and to inform learning and care plan reviews. This helped to minimise the risk of incidents happening again.

We walked around the home and looked at most areas of it. The home was clean and free from odour. Many parts of the home, including its exterior, were recently decorated.

Is the service safe?

People, visitors and staff commented positively about these improvements. A maintenance planner scheduled any remaining work for completion, for example, arrangements were in place for the replacement of some carpets. Staff reported repairs and maintenance in a maintenance book and this showed that these were acted upon quickly. The kitchen area was clean and well managed with food and utensils stored appropriately, refrigeration, freezer and cooked food temperatures were recorded. An Environmental Health audit of the kitchen had taken place earlier in the month and the highest rating of five stars was awarded. People told us they felt safe and were happy with their living environment

Records showed the management company ensured services and equipment at the home were checked when needed to help keep people safe. These included the electrical installation, gas safety certificate, portable electrical appliances, fire alarm and fire fighting equipment. Tests and checks of the alarm and emergency lighting were carried out on a weekly and monthly basis, to ensure equipment was in working order. Fire drills were held regularly to ensure staff were familiar with actions in the event of an emergency. Service contracts were in place to ensure that equipment to support people with their mobility such as the home's lift, standing aid hoists and bath chairs were safe and fit for purpose. Regular water temperature checks and six monthly servicing of thermostatic water mixing valves helped to safeguard against risks of scalding. Appropriate water management systems were in place to safeguard against the risks of legionella, a water borne bacteria.

Staff were provided with information about actions to take in an emergency. Each person had a personal emergency evacuation plan detailing the support they needed to evacuate the building safely. Staff were aware of assembly points and the registered manager was clear where people would be taken initially as a place of safety, should the home need to be evacuated.

Is the service effective?

Our findings

We spent time talking with people and their relatives about the quality of care provided. Responses were positive. People told us they had confidence in the staff who supported them, they felt staff understood their needs and knew how to meet them. Comments included, "I couldn't wish for better staff" ,"I feel the staff look out for me, they want the best for me" and "They always do their best, that's what makes them good and I appreciate that". A visitor told us "I feel my relative is in good hands, I'm kept informed if they're not well". We spoke with a visiting social care professional, who told us "I think staff communicate well".

Mont Calm, Lydd, provides accommodation and support for people experiencing dementia. The registered manager had regard to some published guidance in terms of best practice for a dementia care setting. For example, they provided brightly coloured cups that stood out making them easier for people to see and then use. However, other adaptation of the home was limited. Disorientation and bewilderment are a common experience for people living with dementia and this can be very distressing and frightening. Moving to a care home for people with dementia means they have to adjust to a new environment. It can be very hard to adjust to a new space because adjustment needs memory and learning. It needs a capacity to work out where you are and how to behave. The environment can be made more supportive and enabling with simple adaptations, for example, making sure that what is important is highly visible and the use of signage to help orientate people. However, we found most signage around the home had been removed by people who lived there because it was not suitably robust for its environment. Hand rails blended in to the décor and did not stand out, this would have made them easier to see and use. Where people needed support with continence or occasionally urinated in inappropriate places, toilet doors or door frames and toilet seats were not in contrasting colours. This may have made toilet facilities easier to recognise and enabled some people to be more independent in the management of their continence.

We recommend that the home research and adopt published best practice from organisations, such as The Alzheimer Society or Dementia UK to inform appropriate adaptations to the home for the client group it supports.

During our inspection in March 2014 we found shortfalls in the delivery of new training and in the regularity of refresher training. The management company sent us an action plan in May 2014 telling us a programme of training had begun in April 2014 and would remain on going. During this inspection, we found our previous concerns had been addressed. Training had been delivered as needed. Staff said that if people had specialist needs, for example diabetes, they received the relevant training to ensure they understood how to support them. Training was booked for the following month to support people with behaviour that could challenge and arrangements were in place for the delivery of refresher training in medication and skin integrity. Most staff had received dementia awareness training. Staff told us that the training received was "excellent" and felt it provided them with the skills and confidence to effectively support the people they cared for. Training records and certificates confirmed the training undertaken. The training plan identified when essential training, such as fire safety, health and safety, manual handling and safeguarding required updating.

Some of the staff we spoke with had completed qualifications in health and social care and there was an opportunity for other staff to do so. New staff experienced a three month induction period, followed by a six month probation, which could be extended if needed. The home used Skills For Care common induction standards, which included some class room based sessions, shadowing experienced staff, written assessment workbooks and observational assessments of competency. The registered manager was aware that the common induction standards had been superseded by the care certificate and planned to adopt this for the induction of new staff. This helped to ensure staff had understood what they had been taught and could apply their training in practice. Staff said that induction could be extended or they could be asked to repeat units if necessary. This helped to ensure staff had the right basic level of knowledge and skills to support people effectively and safely.

Supervision of staff took place every six to eight weeks and appraisals annually. Supervisions covered achievements, training and individual actions or targets for staff. They gave staff the opportunity to raise any concerns about working practices and focussed on particular issues on rotation to ensure that each area was discussed over the year and best practice was developed. Staff told us supervisions were

Is the service effective?

useful for their personal development as well as ensuring they were up to date with current working practices. Where needed, we saw that supervision processes linked to disciplinary and performance monitoring procedures.

Staff had received training about the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). DoLS form part of the MCA and aim to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom. Where restrictions are needed to help keep people safe, the principles of DoLS ensure that the least restrictive methods are used.

Where needed, phased DoLS applications had been made to the local authority for people at the home. Acknowledgements had been received, but none of the authorisations had been decided. Staff had a good understanding about the legal requirements of DoLS and were able to give examples of restriction and where least restrictive methods were used. For instance, rather than use bedrails to keep a person safe in bed, floor pressure mats would be considered. This would enable the person to get out of bed when they liked, but alert staff to their actions so that they could be supported if needed.

Staff understood the basis of the MCA and how to support people who did not have the capacity to make a specific decision. Staff knew capacity assessments were decision specific. We heard staff encourage people to take their time to make decisions and staff supported people patiently whilst they decided. Policies reflected that where more complex or major decisions needed to be made, involvement of relevant professionals such as GP's and an Independent Mental Capacity Advocate was required.

Each person had a health care plan. This set out their initial assessment when they arrived at the home and regular, subsequent reviews charted changes in their health needs and on going support needed. Staff were knowledgeable about the people they supported, their specific health needs, choices and preferences and how the needs should be met. People and their relatives told us people saw their GP when they needed to and felt their health care needs were being met. Relatives told us they were satisfied with the health care people received at the home. Chiropodists, dentists and opticians visited the home when people needed them. The registered manager recognised the importance of seeking expertise from community health and social care professionals so people's health and wellbeing was promoted and protected. We saw examples where care plans had been developed with the input of mental health professionals to seek support with particular behaviours. Where people needed more specialised support, for example pressure relieving mattresses to help reduce the risk of skin damage, suitable equipment and checking processes were in place.

We observed a staff handover during the change of shift. This was structured and informative, giving a summary of each person at the home in terms of their wellbeing and any as yet unmet needs. Staff handover was supported by a communication book for the home, which ensured that key messages or actions were known. Staff read and signed the book at the start of their shift, acknowledging its content. This helped to keep staff up to date with people's changing needs and ensure clear and consistent communication within the home.

People received a wide variety of homemade meals and fresh fruit and vegetables were available every day. Home baked cakes were also a particular favourite. The chefs spoke with people about their preferences and asked for feedback about meals. People enjoyed the food and spoke highly of the choices offered to them. One person said, "The meals are delicious, we get a good choice every day." Another person, eating their lunch, told us, "It's very nice". If people did not like what was offered to them on the day, they could always have something else that wasn't on the menu; we saw this occurred during our inspection. The chef was aware of and catered for people with diabetic needs. Relatives were sometimes invited to stay for meals and staff ate meals prepared by the home, all said the food was always good and appetising.

We observed the service of lunch. People who were too frail to come to the dining area or preferred to eat in other rooms were supported by staff. Staff engaged positively and cheerfully with people and particularly with one person, who preferred not to sit down to eat their lunch. Staff provided people with appropriate assistance in a sensitive manner and chatted with the people they supported. Where needed, staff made sure aprons to protect people's clothes were in place before meals were served. People were offered a choice of drinks. We saw and heard staff encourage people to drink to reduce the risk of dehydration. Staff frequently asked people if their meal was to their liking and, if needed, offered to cut up the food.

Is the service caring?

Our findings

People were cared for in a kind and compassionate way. They felt valued and recognised as individuals and said they were happy and content in the home. One person said, "I wouldn't want to live anywhere else." Another person told us "Staff are wonderful." A visitor commented about their relative, saying, "They take great care of her and it is so lovely to see her looking so well." People told us staff listened to them and acted on what they said and this was evident from our observations during the inspection.

Staff knew people well and demonstrated good regard for each person as an individual. Staff spoke with us about the people they cared for with genuine affection and were able to tell us about specific individual needs and provide us with a good background about people's lives before living at the home; including what was important to people. Staff took the time to recognise how people were feeling when they spoke with them. For example when one person became agitated, staff spoke calmly and slowly with the person, encouraging them to speak and help them understand why they were unhappy. Staff knew how to encourage the person to remember a time when they were happier. They chatted with the person about this which helped to calm them. Most of the time, we saw people were addressed by their preferred name, however, on occasion staff referred to people as "darling" or "duck". While people did not seem to mind, it did not always help to orientate people that staff were talking to them.

Staff were clear about how to treat people with dignity, kindness and respect. We observed many examples of positive interactions between staff and people. Staff used effective communication skills, which demonstrated knowledge of people and showed them they were valued and thought of as individual. For example, staff spoke with people at the same level so people did not feel intimidated. They made eye contact and listened to what people were saying, and responded according to people's wishes and choices, including whether people felt comfortable or could do with a cushion or change of position. A member of staff told us, "I take pride in my work and absolutely believe that we offer our residents good care."

Personal care support was offered discreetly to protect people's privacy and dignity. Staff were courteous and polite when speaking to people behind closed doors. For example, we heard a staff member supporting a person in their room. They gave the person time to respond and spoke in a way that was friendly and encouraged conversation. Staff showed understanding of people's equality and diversity. They responded to each person in the home with the same caring manner.

Throughout the day staff spent time with people, chatting and often sharing laughter. People shared experiences with each other as they chatted with staff, reflecting on past times and encouraging each other to reminisce. Staff actively encouraged people to remain independent, prompting and encouraging people to do things where they could for themselves. Birthdays and special events were celebrated, often with a tea party and freshly baked cake.

In conversation staff showed a broad knowledge and understanding of everyone's needs, their character, their preferences and what they liked. Staff knew about people individually and chatted to about things that were relevant to them. For example, previous jobs, where people used to live and what they did during the war. Relatives confirmed they found staff were knowledgeable about the support their relative needed. They commented that whenever they visited, people seemed well cared for and happy.

People were supported to maintain important relationships outside of the home. Relatives told us there were no restrictions on the times they could visit the home, they were always made welcome and invited to events.

Some people had relatives who were involved in their care and could advocate for them if needed, where this was not possible, we saw examples where independent advocates were appointed, for example, about people's accommodation arrangements. Advocacy seeks to ensure that people, particularly those who are most vulnerable, are able to have their voice heard on issues that are important to them, defend and safeguard their rights and enable people's views and wishes to be genuinely considered when decisions are being made about their lives.

Several people spoke to us about how they had been consulted about the redecoration of their bedrooms to reflect their personal tastes and interests. Bedrooms were filled with pictures, photographs and possessions that were important to people and they liked to have around them.

Each person was allocated with a member of the care staff as a 'key worker'. This role included liaising with the

Is the service caring?

person's family if they needed more toiletries or new clothes; keeping their clothes and room tidy. Staff showed attention to the details of care, people's hair was brushed, they were helped with nail care, jewellery or make-up, or assisted with shaving. Clothes were clean and ironed. This level of care helped to demonstrate that staff valued and respected the people they supported.

Is the service responsive?

Our findings

People and their visitors told us they felt confident about raising concerns with the registered manager, and were involved in discussions about their care plans if they wanted to be. One person told us they had helped to write their care plan with the support of staff. A relative told us that they had never had to raise a complaint; they were kept informed about their relatives' care needs and were actively involved in the development of their care plan. Most people said they were happy with the range of activities when they occurred and some relatives acknowledged the difficulty in trying to engage people in activities. None of the relatives, or health and social care professionals spoken with who had dealings with the home, raised any concerns at all about the quality of care people received from staff.

The home employed a part time activity coordinator, providing activities for 20 hours per week split over four days. Activities included music, singing and armchair fitness as well as quizzes, games and celebrations of social events. Activities therefore tended to be group orientated. On the second day of our inspection we spent some time sat in the communal lounge where most of the people were. We observed people's levels of engagement and interaction with staff. The activities coordinator was not working at this time. Two members of staff were present in the lounge, one writing up notes and the second sat with them. The television was on although few people watched it. Other people snoozed and some of the remaining people chatted with each other. Although staff interacted with people, it tended to be to meet a need rather than becoming involved with people and providing interest and stimulation. While more independent people enjoyed using the garden, trips away from the home and helping the maintenance man with gardening and building flower planters, in the absence of the activity coordinator, there was little to engage or stimulate most people. There were no records of the evaluation of activities in terms of feedback obtained from people or observing their reactions. Provision of activities are an area we have identified as requiring improvement.

The service had a complaints procedure, while it was not displayed, it was included in the information given to people and their relatives when they moved to the home. The procedure was clearly written, it contained details of different contacts, but also encouraged people to raise any concerns or complaints with staff or the registered manager in the first instance. The registered manager had an 'open door' policy and made herself available to people and their relatives. There was a system for people to write down any concerns and staff were able to tell us how they would support people doing this. Documentation showed that all concerns and complaints were taken seriously, were investigated, and were responded to in a timely manner. People were confident they could raise any concerns with the staff or the registered manager and said they would not hesitate to complain if they needed to. At the time of the inspection, the home was not dealing with any complaints. However, to ensure that all visitors to the home are aware of how to raise a complaint, if needed, and the process the home will follow, the complaints procedure should be clearly displayed. This is an area we have identified as requiring improvement.

Each person had a pre-admission assessment to ensure that the home would be able to meet their individual needs. These included all aspects of their care, and formed the basis for care planning after they moved to the home. Care plans included people's personal hygiene care, moving and handling, nutritional needs, continence, sleeping, skin care, and pain management. They contained details such as if people preferred a bath or a shower; if they needed help with dressing and undressing; when they liked to get up and go to bed, and preferences about their food, their clothes, and their social activities. People's care plans were discussed with them, and their family members if this was their wish. Care reviews were carried out each month and were up to date. One person told us, "My care is right".

Care plans identified if people could communicate their needs clearly and recognised how people living with dementia suffered from confusion. Staff realised that if people had behavioural episodes, it may be that people were trying to communicate their needs. For example, if a person was shouting or aggressive, it may be because they wanted help to find the toilet, or because they were thirsty or in pain. Where staff noted that one person's needs had begun to change significantly, measures were in place for professional advice and assessment to ensure their needs could be safely met or agree a controlled and informed transition to a new home.

Is the service responsive?

Staff recognised it was important to obtain as much information as possible from people's relatives if the person was unable to communicate clearly, so that they could familiarise themselves with the person's character and treat them appropriately. This included their past history, such as war times, as well as their interests such as music, cooking, gardening and religious beliefs.

The home had developed links with local church groups who visited the home when needed, this helped to ensure people's religious beliefs were supported. People knew they could go to church or see the minister when they visited the home if they wanted to.

Is the service well-led?

Our findings

A registered manager was in post. People and visitors were complementary about the registered manager and staff, commenting positively about how approachable they were. People told us they felt staff made time for them and there was a true open door policy if they needed to discuss anything with the registered manager. We saw and comments confirmed that the registered manager was a visible presence in the home. People and their relatives felt she was thorough when dealing with an issue and would ensure it was addressed quickly. Health and social care professionals who we contacted told us they considered the service to be well run and that they had no concerns. However, we have identified some areas that were not always well led and required improvement.

The registered manager undertook regular checks of the home to make sure it was safe and equipment remained serviceable. Spot checks took place of staff practice at weekends and during night shifts. Detailed audits of the home included areas such as infection control, medication and care plan quality. The registered manager checks were supported by weekly management company visits, which were formalised in a monthly written report. However, checks and audits of the home had not identified concerns about staff deployment or insecure storage of some medicines. The quality assurance framework was not fully effective.

This inspection highlighted shortfalls in the service that had not been identified by monitoring systems in place. The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All care providers must notify us about certain changes, events and incidents affecting their service or the people who use it. These are referred to as statutory notifications. This includes when a home makes applications under Deprivation of Liberty Safeguards to local authorities where restrictions are needed to help keep people safe in the home. Home managers must also notify us about the result of the applications. While relevant applications had been made and were pending decision, statutory notifications informing us about the applications had not been made.

The registered person had not notified the Commission of events which they had a statutory obligation to do so. This is a breach of Regulation 4(A)(a) of the Care Quality Commission (Registration) Regulations 2009.

The registered manager was aware of support organisations, such as Dementia Friends and The Alzheimer's Society, however, the home lacked a management plan or strategy of continuous development to ensure that best care practices for a dementia setting were adopted and driven forward. There was not an ethos of continual development and improvement, by capitalising on published guidance about dementia care to enhance people's experience of living at the home. We have identified this as an area that required improvement.

Policy and procedure information was available within the home and, in discussion; staff knew where to access this information and told us they were kept informed if changes were made. However, when we reviewed the policies we found most had not been updated to reference the 2014 Health and Social Care Regulations. We have identified this as an area that required improvement.

The home's care philosophy set out the principles of providing individual and quality care. The registered manager told us that the values and commitment of the home were embedded in the expected behaviours of staff. Staff recognised and understood the values of the home and could see how their behaviour and engagement with people affected their experiences living at the home. We saw examples of staff displaying these values during our inspection, particularly in their commitment to care and support and the respectful way in which it was delivered.

Staff told us that they attended regular staff meetings, this having last happened in March 2015. They felt the culture within the service was supportive and enabled them to feel able to raise issues and comment about the service or work practices. Although staff said they felt confident about raising any issues of concern around other staff members practice and using the whistleblowing process to do so, some staff expressed reservations about whether confidentiality was always maintained. Staff had complained that sensitive information, such as their private pay slips, were not always afforded the confidentiality required. We discussed these concerns with the registered manager who agreed to take them forward.

Is the service well-led?

Questionnaires were sent out to families in January 2015 and feedback obtained from people, although surveys of health and social care professionals were discontinued due to a lack of response. Returned questionnaires and feedback were collated, outcomes identified and appropriate action taken. The information gathered from regular audits, monitoring and the returned questionnaires was used to recognise any shortfalls and make plans to improve the quality of the care delivered. We saw that the registered manager had developed action plans for improvements to the service, for example, in relation to its maintenance and repair.

Records, including people's care plans were held securely, up to date, well maintained and accessible during the inspection.

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 18 HSCA (RA) Regulations 2014 Staffing **The provider had not ensured that sufficient numbers of staff were deployed to meet the needs of the people using the service at all times. Regulation 18(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered provider had not taken steps to ensure that care and treatment was provided in a safe way for service users including the proper and safe management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems or processes must be established and operated effectively to assess and improve the quality and safety of the services provided and mitigate risks.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered person had not notified the Commission of requests to a supervisory body for standard authorisations under the Mental Capacity Act 2005. Regulation 18 (4A)(a)**