Barchester Healthcare Homes Limited

Stamford Bridge Beaumont

Inspection report

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Ratings

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

Overall summary

This inspection took place on 11 and 12 February 2015 and was unannounced. We previously visited the service on 29 April 2014 and although we did not make any compliance actions, we found that the service required improvement in a variety of areas. We found that people were rushed with their meals, care had not been taken with people's appearance, staff had not made sure that people were sitting safely in their wheelchairs, people were not always referred for specialist assessments, and not everyone was aware of how to express their concerns.

The service is registered to provide accommodation, personal care and nursing care for up to 107 people, some of whom are living with a dementia type illness. The home is separated into five units and three of these are used to accommodate people living with dementia. People are accommodated in single rooms with en-suite facilities. The home is in Stamford Bridge, a village in the East Riding of Yorkshire that is also close to the city of York. It is close to local amenities and has a car park.

The registered provider is required to have a registered manager in post and on the day of the inspection there

Summary of findings

was a manager registered with the Care Quality Commission (CQC); they had been registered since 29 September 2014. 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 told us that they felt safe living at the home. Staff had completed training on safeguarding adults from abuse and were able to describe to us the action they would take if they had concerns about someone's safety. They said that they were confident all staff would recognise and report any incidents or allegations of abuse.

The arrangements for ordering and storing medication were robust but medicines were not always administered safely by staff and recording was not always accurate.

The registered manager and staff had completed training on providing support for people with a dementia related condition although we found that staff were not aware of or following good practice guidance.

We observed good interactions between people who lived at the home and staff on the day of the inspection. People told us that staff were caring and compassionate and this was supported by the relatives and health / social care professionals who we spoke with. People also told us that staff were effective and skilled. Staff told us that they were happy with the training and support provided for them.

People were supported to make their own decisions and when they were not able to do so, meetings were held to ensure that decisions were made in the person's best interests. If it was considered that people were being deprived of their liberty, the correct documentation was in place to confirm this had been authorised.

We saw that there were sufficient numbers of staff on duty to meet the needs of people who lived at the home. New staff had been employed in line with the home's recruitment and selection policies to ensure that only people considered suitable to work with vulnerable people had been employed.

People's nutritional needs had been assessed and people told us that they were satisfied with the meals provided by the home. People were supported appropriately by staff to eat and drink safely and their special diets were catered for.

There were systems in place to seek feedback from people who lived at the home, relatives, health and social care professionals and staff. People's comments and complaints were usually, but not always, responded to appropriately.

People who lived at the home, relatives and staff told us that the home was well managed. The quality audits undertaken by the registered manager were designed to identify any areas of concern or areas that were unsafe, and there were systems in place to ensure that lessons were learned from any issues identified.

We saw that the home was clean and well maintained.

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 care provided was not always safe.

Although staff had received appropriate training on the administration of medication, the arrangements in place for the management of medicines were not robust.

Staff displayed a good understanding of the different types of abuse and were able to explain the action they would take if they observed an incident of abuse or became aware of an abusive situation. However, we identified one incident that should have been referred to the local authority safeguarding adults team which had not been actioned.

We found that there were sufficient numbers of staff employed to ensure that the needs of the people who lived at the home could be met. Recruitment practices were robust and ensured only those people considered suitable to work with vulnerable people were employed.

The premises were being maintained in a way that ensured the safety of people who lived, worked or visited the home but some improvements needed to be made to promote the well-being of people living with dementia.

Is the service effective?

Good

Staff provided effective care.

People were supported to make decisions about their care and best interest meetings were arranged when people needed support with decision making.

We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). We have made a recommendation about staff training on the subject of dementia.

Staff told us that they completed training that equipped them with the skills they needed to carry out their role and this was supported by the records we saw and the other people we spoke with.

People's nutritional needs were assessed and met, and we saw that staff provided appropriate support for people who needed help with eating and drinking.

People had access to health care professionals when required. Advice given by health care professionals was incorporated into care plans and followed by staff to ensure that people's health care needs were met.

Is the service caring?

Good

Staff at the home were caring.

Summary of findings

People who lived at the home and their relatives told us that staff were caring and we observed positive interactions between people who lived at the home and staff on the day of the inspection.

It was clear that people's individual needs were understood by staff, including their wishes for end of life care.

We saw that people's privacy and dignity was respected by most staff and that people were encouraged to be as independent as possible.

Is the service responsive?

Good

The service was responsive to people's needs.

People's needs were assessed and continually reviewed. People's preferences and wishes for care were recorded and these were known by staff, although more effort was needed to ensure that information in care plans was carried out in practice.

People told us they were able to take part in their chosen activities and that they were consulted about the service they received.

There was a complaints procedure in place and most people told us that they were confident that any comments or complaints they made would be listened to.

Is the service well-led?

Good

The home was well led.

There was a registered manager in post at the time of the inspection. The registered manager and other people within the organisation carried out a variety of quality audits to monitor that the systems in place at the home were being followed by staff to ensure the safety and well-being of people who lived and worked at the home.

Most identified issues were dealt with and lessons learned were shared with staff that led to improvements in the service.

There were sufficient opportunities for relatives, staff and health / social care professionals to express their views about the quality of the service provided.

Stamford Bridge Beaumont

Detailed findings

Background to this inspection

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

The inspection took place on 11 and 12 February 2015 and was unannounced. The inspection team consisted of two inspectors from the Care Quality Commission, two Experts by Experience and a Specialist Advisor for dementia care. The Experts by Experience who assisted with this inspection had previous experience of adult social care services.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider, information we had received from one of the local authorities who commissioned a service from the home and information from health and social care professionals. We did not ask the registered provider to submit a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

Prior to the inspection we contacted the local authority safeguarding adult's team and quality monitoring team to ask if they had had any recent involvement with the home.

On the day of the inspection we spoke with ten people who lived at the home, 18 members of staff (including care staff and ancillary staff), seven relatives / visitors, two visiting health care professionals and the registered manager.

We spent time observing the interaction between people who lived at the home, relatives and staff. 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 looked at all areas of the home, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for six people who lived at the home, records for six members of staff and records relating to the management of the home.

Requires improvement

Is the service safe?

Our findings

We spoke with ten people who lived at the home and they told us they felt safe living at Stamford Bridge Beaumont. This was supported by the relatives who we spoke with. One relative told us, "I only have to poke my head outside the door and someone is there to help me with (my relative) if needed." Another relative said, "Oh yes, I have every confidence regarding the safety of (my relative) here. Something we did not have at home."

We saw that care plans included risk assessments for any areas that had been identified as posing some level of risk. These included risk assessments for the inability to use the call bell, use of bath hoists, falls, moving and handling, pressure care, choking and nutrition / hydration. Each person had a document in place called "Safe system of work". This recorded any equipment that the person needed to mobilise safely and the number of staff required to complete each task safely. We noted that risk assessments were updated regularly. A staff member told us, "We make sure the environment is safe for the residents and there's no risk of harm from others." However, we saw that the sluice room on one unit was not locked and could have been accessed by someone who lived at the home. This posed a health and safety risk. We discussed this with the registered manager on the day of the inspection and she assured us that the policy of the home was for sluice rooms to be locked.

We asked the registered manager who checked people for injuries following a fall and we were told that a nurse would always check people over, including the initial check for people who were accommodated in the residential units. Body maps were used appropriately to record any bruising or other injuries; this assisted staff in monitoring a person's condition following a fall or injury.

The training record evidenced that all staff had completed this training on safeguarding adults from abuse during their period of induction and most staff had completed this training again in 2014 and recorded when the refresher training was due during 2015. Staff were able to describe different types of abuse, and were able to tell us what action they would take if they observed an incident of abuse or became aware of an allegation. A senior staff member told us, "There's a policy and the numbers for the safeguarding team and the CQC are available. Everyone knows where they are." Staff told us they would escalate any issue of abuse if no action was taken by the person they had reported it to.

We asked the registered manager if staff had been trained on the use of restraint. They told us that one of the senior nurses had completed Non-Abusive Psychological and Physical Intervention (NAPPI) training; NAPPI is a way of assessing, preventing and managing behaviours that may challenge the service. The senior nurse had cascaded this training to other staff working at the home. Some of the staff we spoke with confirmed they had completed this training.

The registered manager told us that the dependency levels of people were used to determine staffing levels but that a new tool was being introduced that also took the environment into consideration. The registered manager explained the standard staffing levels to us. On residential units there was one senior care worker and two care workers on shift in the morning, and one senior care worker and one care worker in the afternoons / evenings. In the general nursing unit staffing levels were two nurses throughout the day plus six care workers in the morning and five care workers in the afternoon / evening. Staffing in the dementia unit consisted of two nurses throughout the day plus seven care workers in the morning and six care workers in the afternoon / evening. The registered manager told us that they tried to include two senior care workers in the numbers of care staff on shift. There was a minimum of nine staff on duty overnight; the registered manager said this was needed due to the layout of the home. The registered manager told us that they had their own bank of relief care staff and they used agency staff to cover nursing shifts. They said they used a regular team of agency staff who knew the people who lived at the home. We checked the staff rotas and saw that these staffing levels were maintained on most days.

We saw that there were between five and seven catering staff and between four and six domestic staff on duty each day, plus laundry assistants. This meant that care staff and nurses were able to concentrate on supporting and caring for the people who lived at the home.

One relative told us, "I always think there are enough staff and that there's a nice atmosphere" although another relative said, "Staff have been parachuted in for today because you are here! I've never seen a carer sitting all

Is the service safe?

afternoon like this in the lounge." Another relative told us that they were not happy with staffing levels and that they had submitted a formal complaint to the home and were waiting for a reply. People who lived at the home told us that they were happy with the number of staff on duty and one person told us that staff responded quickly when they activated the call bell.

We received information following the inspection to say that there was a shortage of nurses on shift, especially during the night. This person told us that staffing levels were increased when the Commission announced we were going to carry out an inspection. However, our most recent inspection was unannounced and we had not been concerned about staffing levels.

We checked the records for accidents and incidents and noted that one person had said they had been injured by staff whilst being assisted to get undressed. The accident form recorded that the person had sustained an injury that they had reported to staff. We asked the registered manager if this had been reported to the safeguarding adult's team and they told us that no injury had been sustained. This meant that either the recording on the accident / incident form was incorrect or a safeguarding alert had not been made when it should have been.

We checked the recruitment records for six new members of staff. We saw that application forms had been completed and that they recorded the person's employment history, the names of two employment referees and a declaration that they did not have a criminal conviction. Prior to the person commencing work at the home, checks had been undertaken to ensure that they were suitable to work with vulnerable people, such as references, a Disclosure and Barring Service (DBS) first check, a DBS check and identification documents. We saw that a thorough interview had taken place and that interview questions and responses had been retained. There was a system in place to monitor that personal identification numbers (PINs) to confirm a nurse's registration and that Visas to confirm people were able to work in this country had not expired.

We saw that medication was stored safely and medicines that required storage at a low temperature were kept in a medication fridge. We saw that the temperature of the fridge and the medication room were checked daily and recorded to monitor that medication was stored at the correct temperature. Medication was supplied in blister packs: these were colour coded to identify the times that the medication needed to be administered. The medication administration record (MAR) charts were also colour coded to coincide with the blister packs; this reduced the risk of errors occurring.

Staff who administered medication had received appropriate training. However, we observed one nurse administering medication and noted that the medication trolley was not locked when left unaccompanied on two occasions. We saw the nurse hand medication to someone without checking the medication administration record (MAR) chart or the medicine packaging to check that they were administering the right medication to the right person. They did not check that the person had actually taken their medication and did not sign the MAR chart until prompted to do so by a member of the inspection team. We observed another nurse administering medication and noted that they carried out this task correctly, and did not sign the MAR chart until they had seen the person take their medication. However, we noted that people were not always encouraged to take a drink after swallowing their medication and this could have resulted in the medication not being taken effectively.

The system in place to check that the medicines prescribed by the GP were the same as those supplied by the pharmacy was robust. We saw that the arrangements in place for the destruction and return of medication to the pharmacy were satisfactory.

We checked a sample of controlled drugs and saw that the records in the CD book matched the number of medicines in the CD cabinet. We checked medication administration record (MAR) charts and saw that these included a sheet for each person that recorded their photograph and any known allergies. There were protocols in place for the administration of 'as and when required' (PRN) medication. Out of the six MAR charts we checked on one unit for the current month there had been one missing tablet for two people and another person had been given a pain relief patch on the wrong day. On another unit we saw that someone had not been given their Senna medication the previous night. We had initially identified that a large number of tablets were missing for one person but staff explained to us that some of these tablets had been disposed of. Although it transpired that there were only a small number of tablets missing, we found the records to be confusing and this was acknowledged by staff. There were numerous gaps in recording, especially to record that

creams had or had not been administered, and two staff had not always signed hand written entries to confirm that they were correct. This meant that the records of medication administered to people were not completely accurate.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was a comprehensive business continuity plan in place that included information for staff on how to deal with heating loss, severe weather conditions including flood, lift breakdown and gas disruption. In addition to this, each person who lived at the home had a personal emergency evacuation plan (PEEP) in place. These were kept next to the fire panel in each unit so they were easily accessible to the emergency services. The PEEP included the person's full name and the number of the room they occupied, plus information about any equipment used, any complex needs and the number of staff required to assist the person to mobilise.

On the day of the inspection we observed that the home was clean. People who lived at the home and visitors told us they were satisfied with the cleanliness of communal areas of the home and their own rooms. Comments included, "The rooms are cleaned every day" and "My mum's room smells clean."

There was an infection control policy in place and this included the use of cleaning schedules to monitor that all areas of the home were cleaned on a regular basis. We saw protective clothing was readily available for staff. These measures helped prevent the spread of infection. Most staff had completed training on the prevention and control of infection in 2014 and there was a record of when their refresher training was due during 2015.

We saw there was a colour coded system in place which helped identify which piece of cleaning equipment was used in which area of the home. For example, there were separate mops for kitchens and toilets. However, all mop heads were washed at 40 degrees then tumble dried and they were not disinfected. As some of the mops were used in toilets and potentially contained bodily fluid we were concerned that this system of cleaning had the potential for cross infection and asked the registered manager to consider whether there was a more robust method of cleaning mop heads.

There was a sink in the laundry room which we were told was used for soaking clothing that was stained with food. We saw that some plaster was missing around the taps at this sink which made the area difficult to keep clean. We also noted in the bathroom on one unit that the shower head had been leaking. Staff had 'taped' this with medical tape which was water absorbent. This meant there was the potential for bacteria to grow and did not promote good infection control. We told the registered manager about this on the day of the inspection and she told us that immediate action would be taken to rectify this.

Good

Is the service effective?

Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. Discussion with the registered manager evidenced that there was a clear understanding of the principles of the MCA and DoLS. We saw that each care plan had a record of whether a DoLS application needed to be made due to the person being deprived of their liberty. The home's database recorded all DoLS applications and authorisations and when any authorisations were due for renewal.

We saw that each care plan had a record of the person's ability to make decisions. A staff member told us, "We make sure the environment is safe for the residents and there's no risk of harm from others. We do risk assessments and have a discussion with the resident and if they aren't able to make decisions then a best interest decision is made." Staff told us that they were very aware of people's needs. One member of staff said, "It's important to know the residents well. If someone has dementia then you know the triggers and you know how to distract them. With a new colleague you take the lead and explain the difficulties – lead by example."

We spoke with three relatives of people who lacked the capacity to make their own decisions. They all told us that they were involved in their relative's care and when care plans were reviewed. One relative said, "My mother's next review is coming up soon. I do generally feel listened to."

We saw one person who had recently been admitted to the home. They were unsettled and we noted that the two staff in the lounge showed them empathy and patience. They responded to them with friendly conversation that helped to calm them. They did not restrict the person, try to influence their behaviour or make demands on them. This demonstrated that staff had some knowledge of how to work with people who were living with dementia.

We carried out observations in one of the lounge areas of a dementia unit. Our observations did not highlight any concerns about the way in which staff interacted with people who had a dementia related condition. We saw that staff communicated with people who had limited verbal communication by using appropriate touch, eye contact and gestures to help them understand and interact.

Staff confirmed they had undertaken Barchester training on dementia; this included elements of the dementia care matters training and dementia care mapping. However, in discussion with care staff it was apparent that they were not aware of best practice / research including the Prime Minister's challenge, the dementia strategy or guidance provided by the National Institute for Health and Care Excellence (NICE). There was no evidence of good practice guidance being implemented although we saw one care worker discussing photographs and holidays with someone who lived at the home; this was seen to be a positive interaction.

The environmental design in one unit was positive; there was a good use of colour, memory boxes, photographs and signposting. People accommodated on the ground floor had access to outside space, although we noted that the floor surface was uneven and could have created a trip hazard. We were concerned that people on the first and second floors had no access to outside space. There was a clock on the wall in one unit that was too small to be effective. We noted that the doors in the dementia unit were brown in colour with little means of identifying them; we were concerned that this could have been confusing for people and may result in them going into other people's rooms.

The home was warm and welcoming. 'Memory Lane' looked interesting, colourful and inviting and the general nursing units appeared brighter, fresher and livelier than the dementia units. The ground floor dementia unit looked drab and dingy in parts. For example, corridors had dark doors and poor lighting.

Staff told us that communication at the home was effective. The registered manager said that handover meetings were carried out by the nurse or senior care worker leading the shift to their equivalent on the next shift. This information would then be passed to the care workers on duty. A handover sheet was used to record key information that staff needed to be aware of, for example, people who had not been well, hospital appointments and new admissions. These sheets were kept for seven days so that staff could check back if they had been absent from

work. The registered manager told us that any incidents such as accidents or medication errors were discussed at handover meetings, as well as any learning from the incident.

We saw the induction and professional development programme for care workers. This recorded the training that new staff had completed over a three month period. This included the topics of duty of care, consent, medication, awareness of safeguarding adults from abuse, food safety, fire safety, challenging discrimination, comments and complaints and accidents / incidents. New staff were also given a copy of the employee handbook, a code of conduct and forms to record comments from their mentor and their own reflective accounts. When staff had completed their induction training they had a supervision meeting where their learning was identified and an action plan completed.

The registered manager told us that mandatory training for staff included infection control, safeguarding adults from abuse, food hygiene, fire safety, manual handling and health and safety. We saw the record of staff training undertaken in 2014 and this evidenced that most staff had completed mandatory training and the dates when refresher training was due. In addition to mandatory training, most staff had completed training on dementia awareness in 2013 and forty staff had completed refresher training on this topic during 2014. The registered manager told us that a specific training course called "So kind" had been undertaken by staff working in the dementia care units and it was planned for this training to be completed by all other staff during 2015. A small number of staff had not completed training on food hygiene, fire safety and moving and handling. The registered manager told us that they would ensure all staff had completed this training by the end of March 2015.

The care workers who we spoke with throughout the day told us they had adequate and regular training. One member of staff told us, "I know how to meet individual resident's needs through the training I receive and by reading the care plans regularly. We have regular staff meetings and staff support each other during the working day." Another member of staff told us, "I'm up to date with mandatory training and am supported in doing dementia awareness."

We observed the lunchtime experience in one of the units and saw that there was a calm unrushed atmosphere. The room was well lit and spacious and clean tablecloths and napkins were placed on the table. The room was staffed with a 'hostess' and two care workers. There were menus on each table and the choices were read out to people individually. When people requested a small portion this was provided. One person said they would just like soup as they did not feel well and this was accepted and served. We saw that staff chatted to people in an animated way whilst they took their orders.

We also observed that drinks were provided throughout the day. We saw that one person who required their drinks to be thickened to make them safe to swallow was being carefully assisted by a member of staff, who adjusted the person's head position to make it safer for them to drink, and explained what they were going to do and why.

A visitor told us that their relative's food and fluid intake was monitored when they were "Off their food." A member of staff told us, "Residents are weighed monthly and if there is a weight loss of three kilograms or more a diary is started for food and fluids. If the decline continues we refer to the GP and the nurses bring in nutrition advice. The kitchen provides high calorie drinks and snack boxes to try to tempt residents between meals." In care plans we saw evidence that some people had been referred to a dietician when specialist advice was required.

We saw that one person was provided with 'finger foods' as this was the easiest way for them to eat without assistance. However, the food provided was not as easy to eat as it could have been. We discussed this with the registered manager who told us that every effort was made to ensure that menus suited each person's individual needs. The chef showed us the list of people's likes and dislikes and special dietary requirements that was held in the kitchen.

In the dementia unit we saw that staff offered people a choice of meal by showing them the two meals on offer. We saw that the meal looked appealing and appeared to be enjoyed by the majority of people. People told us that they liked the food at the home. Comments included, "Very good food" and "I enjoy the food here, it's very nice." One of the chefs told us that they mostly used fresh ingredients and we saw a large tray of fresh fruit and vegetables in the kitchen.

Good

Is the service effective?

A visitor told us that their relative required a pureed meal. They said that staff assisted their relative to eat their meals when they were not available. On the day of the inspection we saw that people were assisted appropriately with eating and drinking.

We saw that food and fluid charts for one person who took their food and fluids via percutaneous endoscopic gastrostomy (PEG) were kept in the medication room so that this could be monitored by the nurse in charge. The nurse in charge told us that no-one else currently required their food and fluid intake to be monitored.

Staff said they felt they were alert to people's needs and we saw that health care professionals visited people during the inspection. A staff member told us, "We will contact the GP is a resident is unwell or dial 999 if it is an emergency. We always accompany our residents if they need to go to hospital - it would be very distressing for them without someone they know." We were also told by staff that a nurse practitioner from the local GP practice regularly visited the home to review the well-being of people who lived at the home, including their current medication. A relative told us, "If a doctor is needed it happens quickly."

A monthly report was produced in respect of tissue viability. This recorded details of any injuries acquired by people who lived at the home including skin tears and pressure sores. The report included information about the action that had been taken, such as external advice sought, who had been informed and the current state of the person's condition e.g. "Improving" or "No change." In January 2015 one person was recorded as having a pressure sore. A referral had been made to a tissue viability nurse, there was appropriate pressure care equipment in place and a root cause analysis had been completed. On the day of the inspection we spoke with a health care professional who told us that they were confident staff would refer people to a tissue viability nurse when needed and that the registered manager and staff had always followed any advice given.

We saw charts in people's bedrooms that recorded all positional changes. We saw in one unit that pressure cushions had been provided in lounge chairs. However, these would not have been completely effective at relieving pressure because the chair cushion had been removed and replaced with the pressure cushion, rather than the pressure cushion being placed on top of the chair cushion.

We recommend that the service reviews, accesses and implements best practice guidance and research in relation to the specialist needs of people living with dementia.

Good

Is the service caring?

Our findings

We saw that people living on the residential nursing unit looked bright, very clean and well cared for. People living on the dementia unit looked less smart and well groomed, although we acknowledge this may have been due to personal choice.

We asked people who lived at the home and relatives if they felt staff really cared about them. All of the responses were positive. One relative said, "Without exception all the carers have a degree of kindness and compassion which I find touching. The carers care enough but the vast majority do that bit more." One person who lived at the home said, "The best thing is the people. It feels like a family", another said, "There's a lot of the same faces. They are friendly and kind" and a third person said, "The staff speak to me very nicely and they are kind."

Staff told us that they made every effort to provide people with individualised care. One member of staff told us, "It's very much person centred care here. Residents aren't subject to staff routine. You have to care if you work in care – the residents are part of my extended family." Staff told us that they also cared about people's families. One staff member told us, "It's like a family and we keep an eye on the relatives too. If someone didn't come when we expected them, we would ring and see that they were alright, because a lot of them are elderly too."

We observed good rapport between people who lived at the home and staff. Most staff were skilled in engaging people in activities and in conversation, and interacted with people using eye contact and appropriate touch. Staff told us that this was the part of the job they enjoyed. One care worker told us, "The best bit about the job is getting to know the residents and making them smile" and "I always find time to chat, even for five minutes. I feel I make a difference."

However, on one unit we observed that the manner of one member of staff when talking to a person who lived at the home was patronising and inappropriate. This included 'speaking over' the person when they needed assistance whilst discussing another person who lived at the home. In addition to this, some staff were observed to raise their voice and use inappropriate language. We shared this information with the manager at the end of the inspection.

We did observe that some people were left for long periods of time, both in their bedrooms and in communal areas of the home, without contact with staff. However, we also observed some positive one to one interaction between people who lived at the home and staff.

Care plans included good information including risk assessments, assessments and reviews. However, the information did not always match what happened in practice. For example, one person's care plan recorded that they needed to be repositioned every hour but records evidenced that they were repositioned at periods between one hour and three and a half hours. Another person's care plan recorded that they were on a high fibre diet but we were told by a member of staff they were not actually receiving a high fibre diet. A member of staff who we spoke with acknowledged that care plans did not actually match what was happening in practice.

People told us that they were encouraged to be as independent as possible. Comments included, "I'm free to go where I want and to do what I want", "Yes, I get up when I want – I like to get up early" and "I don't feel restricted." A relative told us, "If (my relative) doesn't want to go to bed, they don't make her. She's been known to stay up until one in the morning to watch a film or if she's tired she can go to bed at 7.00 pm. I know this because I check her log. It fits exactly with what she wants."

We asked people if their privacy and dignity was respected by staff. A relative said, "Personal care is always well handled." A member of staff told us, "We take great care to maintain residents privacy and dignity. Doors are closed during personal cares and we reassure them all the time. It's important to make sure we treat them like you'd want your own family member to be treated." We saw that most staff knocked on doors before entering although we noted that they did not always wait for a response, and we saw two nurses who did not knock before entering when they were administering medication. This did not respect the privacy of the people who lived in these bedrooms.

One visitor mentioned that their relative spent their day in their bedroom and only had a brick wall to look at. This had been mentioned at the last inspection and no action had been taken to improve this person's outlook. This was discussed with the manager at the end of the inspection.

Staff said they felt they were alert to people's needs and we saw that health care professionals visited people during

Good

Is the service caring?

the inspection. A staff member told us, "We will contact the GP is a resident is unwell or dial 999 if it is an emergency. We always accompany our residents if they need to go to hospital - it would be very distressing for them without someone they know. There are regular visits by Visioncare and Chiropody." We were also told by staff that a nurse practitioner from the local GP practice regularly visited the home to review the well-being of people who lived at the home, including their current medication. A relative told us, "If a doctor is needed it happens quickly."

Any contact with health care professionals was recorded and any changes to a person's care needs or advice given by health care professionals was recorded in the person's care plan. We saw that there was also an 'urgent visit request' form in place to record this type of contact with health care professionals.

We saw that people had 'end of life' plans and / or advanced care plans in place although in some people's care records these were incomplete. 'Do Not Attempt Resuscitation' (DNAR) notices were in place when this decision had been made by the person concerned or their GP or consultant. We saw that other people had been consulted as part of this decision making process and that DNAR forms had been appropriately completed. We saw that DNAR forms were usually placed at the front of care plans so that they were easily accessible to staff. Both prior to and during the inspection no issues were raised about the end of life care provided to people at the home.

Good

Is the service responsive?

Our findings

We checked the care plans for six people who lived at the home and saw that most of these included a photograph of the person to assist staff with identification, especially when they were new in post. We saw that a person's care needs had been assessed either prior to their admission or when they were first admitted to the home. The topics covered in assessments included mobility, eating / drinking, mental health, speech, washing / dressing, sight, hearing and possible risk factors (for example, frequent falls). Other information obtained at the time of admission was any allergies suffered by the person, medical history, medication, life history and the involvement of health and social care professionals.

We saw that a care plan had been developed for each area of need; this included communication, personal hygiene, mobility, tissue viability, nutrition / hydration, pain, mental health / cognition and cultural / spiritual / social values. We saw that staff had been required to sign a document to evidence that they had read the care plan. Care plans were reviewed and updated each month, or before then if the person's needs changed. Diary entries were made each day to record the care provided and the general well-being of the person concerned.

When a person displayed behaviours that caused staff concern due to the risk that they could hurt themselves or someone else who lived at the home, this was recorded in their care plan. Although the behaviour was described we found that there was no recorded guidance for staff on how to manage these behaviours. This meant that there was no consistent approach to keeping the person safe. The registered manager acknowledged this and said that they would ensure care plans included information to guide staff on how to respond to people's recognised behaviours.

Two visitors told us that their relatives care needs were regularly reviewed, although one person said that they thought staff were task orientated rather than providing personalised care. They said, "I think that the care is good enough though too task orientated rather than personalised."

We overheard conversations between people who lived at the home and staff and it was clear that staff knew people well, including their likes and dislikes and their individual preferences for care. On the day of the inspection we observed that staff were skilled in understanding people's individual needs when they were not able to verbalise these, including their body language, their facial expressions and their gestures. One care plan recorded, "Staff to check (name) every half hour and observe for pain or discomfort by watching facial expressions or body language."

The registered manager told us that they were in the process of benchmarking activities within the home using good practice guidance produced by the College of Occupational Therapy. Some concerns had been identified, including that the activity planning process and documentation did not include relevant risk assessments. An action plan had been produced to deal with any shortfalls.

We spoke with one of the activity coordinators who told us, "Activities are discussed every three months at the residents meeting. They decide what things they'd like including and then they're planned. We use friends and family members of those who can't contribute. I work one to one with many of the residents with dementia." The two activity coordinators produced a timetable of events for each week and we saw activities included life stories, arts and crafts, baking, knit and natter, sing along, exercise, board games and films.

People who lived at the home and relatives told us that interests were encouraged. One person said, "I like playing Scrabble and there's a group who play one to two times a week in the lounge." We saw two people who lived at the home doing word puzzles with two visitors. We observed one member of staff sharing a picture book with a person who lived at the home, and that the person responded well to this interaction and smiled. Other staff sat with people and held their hands when this was felt to be appropriate and it was clear that some people found this comforting. We saw staff engaging people in conversation about their family and friends, reminding them of either things they had done or when their visitors usually came, and encouraging them to look forward to this. Staff told us that there was a church service every Thursday morning and several people who lived at the home told us that they liked to attend the service.

However, we did not see any activities taking place that were specifically designed for people with dementia. The area of the home called Memory Lane was created as a reminiscence area but we did not see it being used as an

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Is the service responsive?

activity during the day. We did see one person walking along the area alone, using some of the materials provided. Staff told us that they did not arrange activities around this area but that it was something they would consider. One relative told us, "There are activities going on though not anything specific for people with dementia that I know of. Certainly no special one to one activities."

One relative told us that the views of people who lived at the home were listened to. They said, "When I suggested tidying the papers away (on the window ledge) the carers were all for it. But (my relative) wanted things left as they were and that's what happened. It was her choice." We saw that one person's care plan recorded that they had been offered pureed meals due to the risk of choking but they had declined. They had signed a disclaimer to this effect and had reverted back to a 'normal' diet. The person's GP and speech and language therapist (SALT) had been made aware that this was the person's decision.

A person who lived at the home told us that there was a committee for 'residents' and friends. They said that they did not belong to the committee but added, "If I had an idea I wouldn't be frightened to suggest it." In addition to this, people who lived at the home were invited to complete satisfaction surveys and care plan reviews were held. This gave people the opportunity to comment on the care and support they received.

There was a policy and procedure in place on how to make a complaint and this was displayed within the home. People told us that they knew who to go to with concerns and complaints and said they were confident in doing so. One person who lived at the home told us, "The manager pops in to have a chat regularly when she does her daily rounds."

One complaint made to the home had also been investigated by the local authority safeguarding adult's team and the outcome of the investigation was inconclusive. The registered manager was aware that the complainant was unhappy with the care their relative had received at the home and was not satisfied with the investigation undertaken by the safeguarding adult's team. We were concerned that this information had not been treated as a complaint by the home and investigated following their own complaints procedure. The deputy manager told us that they had conducted an in-house investigation into these concerns but acknowledged they had not given the complainant feedback. They agreed that they would now conduct a formal investigation and share their findings with the complainant. Another relative told us that they had submitted a complaint in September 2014 and not received a reply. We mentioned this to the manager and they told us that they were not aware of a complaint being received from another relative but that they would look into this.

We saw that complaints received were recorded and this included details of the response to the concern and of the actions taken. Discussion with the manager confirmed she did feed this information back to the staff team but did not have any record of any learning or service development from concerns raised.

We recommend that the service finds out more about activities that are specifically designed to meet the needs of people living with dementia.

Good

Is the service well-led?

Our findings

Staff who we spoke with told us that there was an open culture at the home. One member of staff told us, "It's a lovely environment – the nicest job I have ever had", another said, "Everyone is treated equally. It's open and not cliquish at all. People can speak openly about concerns" and a third person said, "There is an open attitude – I see it like a family." Relatives told us that they found the registered manager to be approachable and that the home was well organised. Comments included, ""Well, I think it must be well managed because there's such a very nice atmosphere and everyone makes you welcome.", "It's a well organised place" and "The managers door is always open."

We saw that the induction manual given to new staff included information about the philosophy and values of the service and organisation. The registered manager told us that this 'ran through' all training sessions. For example, moving and handling training included information on respecting dignity and valuing relationships. We were told that employment interviews were designed to assess the applicant's values and we saw a letter in personnel files that had been sent to all staff setting out the vision for the business.

We asked the registered manager if they had appointed any "Champions" within the service. She told us there were plans in place to have a "Falls" champion as part of the "Footsteps" falls programme. The registered manager told us that they currently prepared a monthly summary on nutrition and that a senior care worker and a cook would take on the role of "Champion". It would be their responsibility to ensure that relevant information about nutrition was stored in the kitchen and in a person's care plan.

The registered manager showed us the clinical governance report and we saw that it included an analysis of accidents / incidents, hospital admissions, complaints, safeguarding, infection control, infections, notifications, nutrition and Deprivation of Liberty applications / authorisations plus any other audits carried out in respect of the service provided. They said that they were introducing a formal clinical governance meeting from the day following our inspection. This would give them the opportunity to discuss the information recorded on the clinical governance report and monitor the action taken to make any identified improvements.

Staff told us that they were well supported and well managed. One staff member told us, "I've every confidence in the manager. I could go to her about anything and she'll take it seriously" and another said, "It's very well managed here and we have really good communications." We saw that staff attended meetings and had one to one supervision meetings with a manager. These are meetings when an employee meets with a senior member of staff to discuss their training needs, any concerns about the people who they support and any issues in respect of their role. Staff also had annual appraisals and they had the opportunity to record their views about their practice prior to these meetings.

Any accidents or incidents were recorded in a person's care plan and any injuries sustained were recorded on a body map to assist staff in monitoring the person's recovery. However, some of this information was brief. For example, one person had fallen in the home and the long term action required was "To prevent re-occurrence." There was no information as to what the actual actions should be to prevent re-occurrence. Accidents and incidents (along with complaints and any incidences of pressure sores) were dealt with by the registered manager and then entered on to the organisation database. These details were analysed by the organisation and returned to the home on a ' data dashboard' document; the analysed information was used to identify any areas for improvement or any further action that needed to be taken.

The registered manager told us that any incidents such as accidents or medication errors would be discussed at handover meetings, as well as any learning from the incident. This information would also be recorded in the home's "Lessons learned" file. Information in this file would be discussed at staff meetings.

There were regular (bi monthly) visits undertaken by a senior manager to review the systems in the home. These were called "Quality first visits". Any areas for improvement were recorded on an action plan and included, for example, improvements required to care planning or peoples monitoring charts. Different audits were also undertaken by staff at the home. We saw in a nutrition audit that the provider had scored the service at 91% which was identified as an improvement. The audits also reviewed corporate business for example, the last CQC

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Is the service well-led?

report and the occupancy of the home, staff training care planning and risk assessments. The audits included a review of documents in the home and speaking with people who lived in the home.

There were audits in place to monitor the prevention and control of infection. The registered manager told us an annual statement of any incidents in the home was completed. This helped to make sure the service had an overview of the current systems and how any incidents were managed in respect of infection control.

A member of staff gave us an example of how they had changed their practice as a result of audits that had been carried out. The said that they had started a "Mealtime experience" and had found "If staff sat and ate the same meal with residents, chatting with them and encouraging them, then we noted more weight gains than losses."

We saw results of a survey which recorded the outcome of a "Your care survey" completed by people who lived at the home in 2014. These were made available to people who lived at the home and visitors to the home. We also saw minutes of meetings that had been attended by relatives. This showed people who lived at the home and relatives / friends were involved in the running of the service and were consulted on how well it was meeting people's needs.

We saw emails that had been sent to staff to ask for feedback regarding the service. In addition to this, meetings were held with different staff at different times of the year. They covered different topics including recording in people's care files, staff training and supervision meetings. We reviewed these records and found that the meetings were held for different staff members at different times of the year but there appeared to be some inconsistency with the frequency of these meetings. For example, the minutes of a care workers meeting in one unit evidenced that there had been five meetings during 2014 and the minutes for another unit evidenced that there had only been one meeting for staff during the same period. There were only two records of a nurses meeting in 2014; one for night staff and one health and safety committee meeting. It was not clear how information was shared equally amongst the full staff group.

We saw the records of the maintenance work carried out by the home's maintenance person. These evidenced that regular checks were carried out on equipment used to ensure that it was safe for people who lived at the home and staff to use. The home had recently received a score of 5 for food hygiene from Environmental Health; this is the highest score that can be awarded.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person had not protected service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for recording and safe administration of medicines used for the purposes of the regulated activity.**