Barchester Healthcare Homes Limited

Mallard Court

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

Summary of findings

Overall summary

This inspection took place on the 22 and 23 February 2016 and was unannounced. At our last inspection of the service on 10 June 2014 the registered provider was compliant with all the regulations in force at that time.

Mallard Court provides both nursing and personal care for older people who may be living with dementia or a physical disability. The home is situated in the town of Bridlington. Seventy people can be accommodated in a mix of 64 single and three double rooms that are located on two floors with lift and stair access. All but two rooms are en-suite and there are supplementary bathrooms and shower rooms. There are lounges and a dining area on each floor. The grounds of the home are designed to be accessible to people with mobility difficulties.

The registered provider is required to have a registered manager in post and there was a registered manager at this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we found that the home was not always safe. Risks to the health and safety of people using the service were not always thoroughly assessed and effectively managed and this placed people at risk of otherwise avoidable harm. This was a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

The recording and administration of medicines was not being managed appropriately in the service. This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

You can see what action we told the provider to take at the back of the full version of this report.

People told us that they felt safe living at the home. We found that staff had a good knowledge of how to keep people safe from harm and that there were enough staff to meet people's needs. Staff had been employed following appropriate recruitment and selection processes.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. The plans of care were individualised to include preferences, likes and dislikes. People who used the service received additional care and treatment from health professionals based in the community.

People spoken with said staff were caring and they were happy with the care they received. They had access to community facilities and most participated in the activities provided in the service.

Staff received a range of training opportunities and told us they were supported so they could deliver effective care; this included staff supervision, appraisals and staff meetings.

The registered manager monitored the quality of the service, supported the staff team and ensured that people who used the service were able to make suggestions and raise concerns. Immediate action was taken by the registered manager with regard to the concerns we raised with them during our inspection.

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.

Risks were not always effectively managed and this impacted on the safety of people using the service. The recording and administration of medicines was not being managed appropriately in the service.

There were processes in place to help make sure the people who used the service were protected from the risk of abuse and the staff demonstrated a good understanding of safeguarding vulnerable adults' procedures.

There were sufficient staff on duty to meet the needs of people who used the service.

Is the service effective?

Good

The service was effective.

Staff received relevant training, supervision and appraisal to enable them to feel confident in providing effective care for people. They were aware of the requirements of the Mental Capacity Act 2005.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

We saw people were provided with appropriate assistance and support with regard to nutrition and hydration and staff understood people's nutritional needs. People reported that care was effective and they received appropriate healthcare support.

Is the service caring?

Good

The service was caring.

People were supported by kind and attentive staff. We saw that care staff showed patience and gave encouragement when

supporting people. People were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day to day needs.

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with.

Is the service responsive?

Good

The service was responsive.

Care plans were in place outlining people's care and support needs. Staff were knowledgeable about people's support needs, their interests and preferences in order to provide a personalised service.

People were able to make choices and decisions about aspects of their lives. This helped them to retain some control and to be as independent as possible.

People were able to make suggestions and raise concerns or complaints about the service they received. These were listened to and action was taken to address them.

Is the service well-led?

Good

The service was well-led.

The registered manager had a visible presence around the service and people said they were able to meet them and talk with them on a regular basis.

The registered manager 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 there. We had some concerns that these audits were not fully effective, but the registered manager acted quickly on our concerns and took immediate action to improve practices.

Staff were supported by their registered manager. There was open communication within the staff team and staff felt comfortable discussing any concerns with the registered manager.

Mallard Court

Detailed findings

Background to this inspection

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

This inspection took place on 22 and 23 February 2016 and was unannounced. The inspection team consisted of two adult social care (ASC) inspectors on day one and one ASC inspector on day two.

Before the inspection we did not ask the registered provider to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at information we held about the service, which included notifications sent to us since the last inspection. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service. As part of the inspection process we contacted the local authority safeguarding adults and commissioning teams who informed us that they had no concerns about the service.

At this inspection we spoke with the registered manager, deputy manager and the regional manager. We also spoke with seven staff members and then spoke in private with one visitor and five people who used the service. We observed the interaction between people, relatives and staff in the communal areas and during mealtimes. Due to the complex needs of some people who used the service we also 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 to us.

We spent time in the office looking at records, which included the care records for four people who used the service, the recruitment, induction, training and supervision records for five members of staff and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe, if the staff assisting them had the right skills and if they felt the premises were safe and secure. Comments included, "Yes, the staff and the general atmosphere are good and make me feel safe", "I feel safe when they use the hoist and staff know what they are doing" and "I feel perfectly safe, I have never witnessed any bad practices." One relative told us, "I am here most days and I am confident [Name] is safe and well looked after."

We saw that the registered manager monitored health and safety within the service and carried out regular health and safety risk assessments of the premises (including grounds) and equipment. They also monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and acted upon as needed. We were given access to the records for accidents and incidents which showed what action had been taken and any investigations completed by the registered manager. For example, one person had an increased number of altercations with other people using the service. One-to-one support was put into place and the number of incidents decreased over the following weeks. However, we found that staff monitoring and recording of risk within the service required some improvement that did not appear to have been identified by the registered manager's audits.

When a person first came to live in the home, staff completed a series of risk assessments to help them identify the person's level of need. Where staff found an elevated risk, they completed a 'targeted intervention' plan to identify strategies they could use to ensure the person was as safe as possible. For example, where a person was found to have had previous falls, staff completed a targeted intervention to help reduce the risk of falls in the future. Although we found risk assessments to be appropriate, staff had not always included a robust or detailed evidence base for them. For example, one person had been identified as at high risk of falls, but staff had not included details of previous incidents, instead stating the person had "Loads of falls" in the past. This meant it was not clear how the risk assessment in place had been established or if mitigation strategies reflected these appropriately.

In addition, the information in related risk assessments was sometimes inconsistent. For example, one person's sleeping risk assessment indicated they had use of a walking frame. However, the person's mobility risk assessment did not mention a walking frame. We saw that, although staff documented updates to risk assessments on a monthly basis, another person had their falls risk assessment updated in January 2016 and staff had not included details of recent falls in this assessment.

We found evidence staff completed incident reports, such as after a fall. However, there was not always evidence that appropriate follow-up action had been taken and reports were not always detailed. For example, staff had completed an incident form after they found one person had an injury to their face from a fall but there was no indication of whether they had sought appropriate medical advice. Staff had also not included a time of the incident on the report. In another person's care plan, we found staff used a falls tracker to support falls incident investigations and to identify strategies for reducing risk. However, this tool was not always used accurately. For example, we found staff had noted only one of three falls in the tracker, which meant the risk assessment was based on inaccurate information.

Each person had a communication care plan that we found was personalised and included consideration of specific barriers to communication. For instance, staff had assessed one person with macular degeneration as at high risk for communication problems because they could not see their bedroom call bell and were at risk of falling. To ensure the person remained safe, staff conducted an hourly check on them on a 24-hour basis. However, an incident record indicated staff had not conducted the checks consistently, with a three-hour gap in checks identified after the person was found to have fallen during the night. This person's care plan indicated they had a floor sensor, which should have alerted staff if the person had fallen in the night. We asked a member of staff about this. They did not know if the bed sensor had failed to operate or if staff had not heard the alarm.

We concluded that health and safety risks were not always thoroughly assessed and effectively managed and this placed people at risk of otherwise avoidable harm.

This was a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

A weekly check of medicine stock and records was carried out by the staff and any discrepancies were reported to the registered manager and investigated. We looked at records of 'near misses' where medication errors had been noted and action taken to prevent any reoccurrence. We found that where the same staff made repeat mistakes then retraining and supervision sessions had taken place. Discussion with the registered manager also showed that disciplinary action would be taken if staff practice did not improve. A letter to this effect had been sent out to all staff in December 2015. The most recent medicine audit for January 2016 showed that no issues were found, which indicated that staff practice and recording was improving. However, our checks of the medicine system and stocks held showed that staff practice was not satisfactory.

We looked at the systems in place for medicines management. We assessed fifteen medication administration records (MARs) and looked at storage, handling and stock requirements. We found that appropriate arrangements for the safe handling of medicines were not always in place.

Medicines were stored securely and the keys were held by the senior carer or nurse on duty. Controlled drugs were regularly assessed and stocks recorded accurately. Room and fridge temperatures were recorded daily. Medicines were administered by either the nurse on duty or a medicines trained carer. We observed a carer administering medicines during our visit. Medicines were administered safely and documentation directed carers to a person's preference for administration.

People and relatives told us that medication on a personal level was handled well. One person told us they were on regular pain killers and said they got them "Pretty well on time." We saw the nurse enquiring if people were in pain and administering pain relief medicine as prescribed where needed. People were given drinks to swallow their tablets with and time to take them without rushing.

However, the ground floor morning medicines trolley round was not administered in a timely manner and was still taking place at 11:00am. Staff told us that interruptions from visiting health care and social care professionals meant the care worker giving out the medicines was constantly having to break off to see to these visitors. This meant people did not receive their medicines on time and as prescribed. Discussion with the registered manager indicated that they were currently recruiting for a head of unit and this individual would deal with any professional visitors, leaving staff to give out medicines more effectively.

The clinical lead was responsible for ordering and checking medicines held within the service and disposing

of unwanted medicines. They were able to describe the system to us and showed us how they carried out their checks. The documentation we saw showed that any prescription errors had been followed up with the GP and the pharmacy that dispensed the medicine. We observed that medicines were disposed of in a timely manner.

Transdermal Application Records (body maps) were used to help ensure pain patches were used safely by ensuring they were applied to different areas of the body. We observed that one person had their patch applied to the same skin areas more frequently than recommended. This increased their risk from this medicine.

One person was prescribed an antibiotic to be administered three times daily. The amount supplied provided a three/four day course (10 doses). However, fourteen doses had been administered and the course had been continued past the three/four days without consultation with the GP. This meant the antibiotic may not have been effective.

We looked at a selection of medicine records on both the nursing and residential units. We saw evidence that staff were signing for medicines they had administered, but on three out of fifteen MAR charts we looked at the records for administration did not match the amount of medicine we found in stock. The medicines we checked and where we found incorrect balances included tablets taken on a daily basis and others that were taken as and when needed (PRN). This indicated that either people were not getting their medicines or that staff were not recording these correctly. This was not safe practice and could potentially result in people being put at risk of harm.

Topical medicine charts were in use for the application of external use creams and lotions. However, we found that instructions for use of these medicines were vague or not recorded on the charts and staff were not signing when they administered these. This meant we could not be certain that these were being administered appropriately and as prescribed.

These findings evidenced a breach of Regulation 12 (1)(2)(g) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered provider had policies and procedures in place to guide staff in the safeguarding of vulnerable adults from abuse (SOVA). The registered manager described the local authority safeguarding procedures. This consisted of a risk matrix tool, phone calls to the local safeguarding team for advice and alert forms to use when making referrals to the safeguarding team for a decision about investigation. There had been instances when the safeguarding risk matrix tool had been used, when alert forms had been completed and when the CQC had been notified. These were completed appropriately and in a timely way. This demonstrated to us that the service took safeguarding incidents seriously and ensured they were fully acted upon to keep people safe.

We spoke with staff about their understanding of SOVA. Staff were able to clearly describe how they would escalate concerns both internally through their organisation or externally should they identify possible abuse. Staff said they were confident their registered manager would take any allegations seriously and would investigate. The staff told us that they had completed SOVA training in the last year and this was confirmed by their training records. The training records we saw showed that all staff were up-to-date with safeguarding training. A member of staff had developed a pocket-sized card to help prompt staff on the principles of effective safeguarding. This included information on the Duty of Candour, whistleblowing and the Mental Capacity Act (2005).

We spoke with the maintenance person and looked at documents relating to the servicing of equipment and the maintenance of the home environment. There were current maintenance certificates for the fire alarm system, the nurse call bell, moving and handling equipment including hoists, the electrical installation, portable appliances and gas installations. Clear records were maintained of daily, weekly, monthly and annual checks carried out by the maintenance person for wheelchairs, hot and cold water outlets, fire doors and call points, emergency lights, window opening restrictors and bed rails. These environmental checks meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. This helped to ensure the safety of people who used the service.

The registered manager spoke with us about the registered provider's business continuity plan for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. The plan identified the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met. This was last reviewed in July 2015. Personal emergency evacuation plans (PEEP's) were in place for people who would require assistance leaving the premises in the event of an emergency. These were kept in their care files and were up to date. We saw that the fire risk assessment was reviewed in July 2015, staff had in-depth fire training and fire drills were carried out on a monthly basis.

We looked at the recruitment files of five members of staff. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured they were aware of what was expected of them. The registered manager carried out regular checks with the Nursing and Midwifery Council to ensure that the nurses employed by the service had active registrations to practice.

A senior care assistant told us there were enough staff on shift according to the dependency tool, which the registered provider used to determine staffing levels. However, they said, "I know the dependency tool shows we have enough staff but we have a lot of people with complex care needs here, especially around dementia. We often feel quite stretched." We spent time observing daily life on both floors of the service and we found that staff did not appear rushed on the two days of our inspection.

The registered manager told us that the dependency tool was used each time a new person came into the service. We saw that this was last reviewed on 9 February 2016. Information from the dependency tool showed that the required staffing levels were three nurses and ten care staff on duty each morning and afternoon/evening, and one nurse and five staff on duty at night. At the time of our inspection there were 62 people in residence.

We looked at the last four weeks rosters leading up to and including the week of our inspection. We saw that the staffing levels were not always consistent due to annual leave or sick leave. Where able the registered manager had covered the shifts, but there were some occasions where staffing numbers were down by one person for the odd day. We also saw that when everyone was available for duty there were days when additional staff were on duty to allow others to attend training, take people for appointments and for meetings to be held. This showed that the registered manager monitored the staffing levels and wherever possible maintained the levels needed to meet people's needs. Agency staff were being used for one-to-one care and cover for night shifts and the weekly hours used were consistent. The registered manager told us that recruitment for new staff was on-going and they were waiting for references and DBS checks to be returned before new staff could start work.

We saw that agency staff were given an induction prior to working in the service. This covered an introduction to the service, emergency procedures, health and safety processes, documentation and, for trained staff, medicines. The induction form was signed by both the agency staff and the person inducting them. The service held profiles on each agency staff giving them evidence of their qualifications and recruitment safety checks from the agency. However, only some of the profiles included a photo of the agency worker, which meant others had no identification evidence on them. The registered manager said they would contact the agencies and get the photographs for those missing on the files.

There was a very strong odour that was apparent close to the lift on the dementia care unit. It was a 'fusty smell' and did not abate at any time during our inspection. Discussion with the domestic staff indicated that carpets and furniture were regularly cleaned and the cleaning records and observation of the unit confirmed this. The registered manager and the regional manager assured us that this had been recognised by the registered provider and that plans to totally refurbish and redecorate the unit had been approved. We were supplied with this information during the inspection and we were contacted the week after with confirmation that work on the unit had started. All other areas we looked at were clean, tidy and free from malodours.

Good

Is the service effective?

Our findings

We found staff had developed effective communication strategies to support people with complex needs, which also protected their dignity and wellbeing. Where staff had identified a person to demonstrate aggressive behaviour, they had conducted an assessment to identify triggers to this. For example, staff had found one person became verbally abusive towards them as a result of frustration they experienced when trying to find words. To support the person and reduce their frustration, staff had started new approaches to communicate with them, which gave more time and prompts to find words they were trying to find.

We found the staff team worked well together and in the best interests of people. For example, one of the maintenance staff had developed a very positive relationship with a person who had previously demonstrated a high level of unpredictable aggression towards staff. We asked this member of staff about the situation. They said, "We've built a relationship because I noticed they were very upset about their family. I told them about my family and this gave us some common ground, something to talk about. Now we sometimes sit and have a cuppa and talk about children and it makes them feel better."

Staff used established, evidence-based strategies and techniques to support people effectively. For example, care staff were trained in the use of the DICE (Describe, Investigate, Create, Evaluate) tool for communication in people with dementia. This is a four-part tool used as an empowerment strategy to help caregivers reduce the instances of anxious behaviour in people with dementia. From looking at records we saw staff used this tool to support people in specific areas of need such as personal hygiene, continence, mobility, tissue viability, nutrition, breathing and pain management. Staff had completed additional DICE assessments for one person with psychological needs; they had identified when the person had withdrawn from any involvement in their care planning and support. As part of this, staff had completed a cognitive assessment to identify if the person had changed needs in mental capacity. Staff were also trained in the use of non-violent intervention techniques to manage and support people with aggressive or violent behaviour that challenged the service.

We looked at the training records of five members of staff. We found staff had up to date training in infection control, dementia awareness, diabetes care, food safety and allergies, the Mental Capacity Act (2005), safeguarding and malnutrition. Drug competency training was delivered specifically in relation to the needs of individuals. For example, training included the care of a person who often refused their medicine as well as a check of each person's prescription and medicine side effects. Senior staff had training in mentoring and leadership. Staff were also trained in the 'Barchester Footsteps' programme; a targeted study programme to help staff support active ageing and reduce the risk of falls. We asked a senior care assistant about this. They told us they were "Very impressed" with the training they had been offered and said safeguarding training was specialist enough to help them meet the needs of people. They said, "We have a care practitioner who delivers safeguarding training, it's much improved since that started."

We asked staff how they ensured their skills were developed in line with the needs of people they provided care and support for. A senior care assistant said staff tended to be deployed to the same floor on a daily basis. This meant they got to know people well and could develop their practice according to the acuity of

people. The member of staff gave an example of the impact of this. They said, "We had a person who came to live here who had not been given long to live and was bedbound. But we were persistent and didn't want to let them just waste away in bed. Now they're up and about, using a walking frame." They introduced us to another person who had previously refused to come out of their bedroom because they did not like the member of staff (from a nurse agency) who was assigned to work with them on a one-to-one basis. Care staff worked with the person to find out what had caused the problem and were able to recruit a more suitable nurse from the agency. As a result the person was happier and spending more time socialising for example, during mealtimes and during social activities.

Staff received supervision with a senior member of staff every two months. One member of staff said, "The supervisions are a useful process. They highlight any problems and we can ask for extra support." We found the supervision records we looked at had been conducted in a manner that supported staff to identify areas of good practice and to create action plans for future development. The registered manager conducted an annual appraisal with each member of staff. We found some appraisal records did not include structured or detailed information regarding staff development. For example, the appraisal of one member of care staff did not include any evaluative comments or manager feedback.

From looking at care records and speaking with staff we found people had regular access to multidisciplinary healthcare professionals. This included regular visits from a GP, district nurse, the Speech and Language Therapy (SALT) team, an asthma nurse and the community mental health team. We saw staff had worked closely with the community mental health team to support a person who had demonstrated aggressive behaviour. For example, they had completed a risk assessment and an investigation had identified the cause of the behaviour. This meant the person had benefited from liaison between staff and health care professionals.

Staff used the Malnutrition Universal Screening Tool (MUST) to monitor people for malnutrition. We saw this tool was used alongside choking and swallowing risk assessments to provide a comprehensive overview of each person's nutrition needs. People were able to eat their meals wherever they wanted, such as in the privacy of their bedroom.

We saw that eight people were using the ground floor dining room. People were able to have a choice of drinks with their meals and everyone said, "The food is very good." We sat with one person who was eating in the lounge and they told us they preferred eating there. This person told us, "My appetite is a bit up and down. The staff keep trying to tempt me with different meals, but it depends on how I am feeling." We saw that they tried to eat some soup that the chef had made for them and they said, "It is very nice, but I am not that hungry." They enjoyed a cup of tea with lemon and they tried some scampi and chips later on in the day. Their relative who was sat with them told us, "[Name] usually asks for soup and a pudding. They have a sweet tooth so enjoy these."

We also observed the lunch service on the first floor of the home. We saw staff welcomed people with a genuinely warm and friendly approach, which was successful in encouraging people to sit with other people for lunch. We saw a person who had been away from the home for a while was delighted when a care assistant noticed them and said, "It's lovely to have you back, we missed you." One person who felt unwell wanted to stay in the lounge to eat. A senior care assistant knelt in front of them, made positive eye contact and reassured them that they would help them to eat lunch. We saw a senior care assistant spent time speaking with the person and was able to encourage them to eat a bowl of soup. We noted that people preferred to eat in the privacy of their bedroom and they were supported to do so.

There was a sociable, collaborative atmosphere at lunchtime between people and different members of

staff. For example, the chef spoke with people and asked them personally if they were enjoying their meal. We saw they were able to meet the expectations of a person to whom formal table manners were important. Another person ate a full meal after previously refusing it and telling staff to leave them alone. We saw the persistence and encouraging approach of staff contributed to this. During lunch people were given adequate liquids to stay hydrated and staff promoted fresh fruit options.

The dementia experience report carried out by the registered provider and the latest environment report raised significant concerns about the Memory Lane unit. They noted that the dining room was cramped and overcrowded and some people had to use the downstairs dining room. An action plan to address these issues had been agreed within the company and work was due to start on the refurbishment and redecoration of the unit the week following our inspection. Some aspects of the Memory Lane unit showed that consideration to dementia design principles had been made. These included pictorial signage on bathroom doors and memory boxes on bedroom doors making it easier for people with cognitive impairment to find their way around the service.

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

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

Records showed that 11 people who used the service had a DoLS in place around restricting their freedom of movement and we saw that these were kept under review. Documentation was completed appropriately by the registered manager who displayed a good understanding of their role and responsibility regarding MCA and DoLS.

The care records we saw reflected a general understanding of the principles and requirements of the MCA and DoLS and staff who spoke with us demonstrated a general grasp on the concept of MCA and DoLS. One staff member told us "People have the right to make their own choices about everyday things. We would not make anyone do something they do not want to. People have the right to say no and we respect that." Where a person had a recent photograph in their care plan, staff had obtained their consent for this. Staff had also documented how they had obtained consent for risk assessments and care planning. Where a person was able to give their own consent, this was documented even if they were not able to sign a consent form themselves.

Good

Is the service caring?

Our findings

During our inspection we observed interactions between people and staff. We found most staff had a naturally caring and empathic manner and were skilled at providing effective, compassionate emotional support. For example, we saw one person was anxious and confused because they were disorientated. A senior care assistant demonstrated good knowledge of how to support the person by taking them by the hand and diverting their attention by starting a new conversation. Walking around the floor calmed the person and the member of staff was very patient, spending as much time with them as was needed for them to relax. This member of staff told colleagues they would be away from the floor for a while so they could help this person. We saw this allowed them to work at a pace directed by the person.

One care assistant did not demonstrate the same level of compassion when approached by a person who was upset. The person was asking repeatedly to be allowed to go home and the care assistant had an abrupt manner with them. They said, "I can't do what I can't do." We asked other members of the team about compassionate care. They said, "People can ask why they're here and we tell them it's for their safety and so they can be looked after properly. When they realise everything we do is to help them it usually relaxes them."

During lunch, we saw some members of the care staff team did not facilitate a consistently positive relationship with people. For example, one care assistant told a colleague a person in the lounge did not want to join people in the dining room for lunch and imitated their speech. This was conducted in a communal area where the person being discussed could hear. The senior member of care staff resolved the situation by sitting with the person who did not want to leave the lounge and encouraging them to eat lunch. This demonstrated a notable gap in the standard of training and ability of staff to support people with different levels of need.

Discussion with the registered manager about these concerns showed that they had recognised some staff needed further training around dementia care and specialist needs to improve their knowledge. This training had been arranged for 18 March 2016. The registered manager also took immediate action and went onto the unit to speak to the staff mentioned above and the staff in charge of the unit to ensure practices improved.

From looking at care plans, we saw each person had a section for their personal life history. This could be used to document important relationships, significant events and other personal information to help staff get to know people and understand their needs. The personal histories we looked at had been completed inconsistently. For example, one person had no significant relationships, memories, feelings, family traditions or holidays, social groups or current interests listed. We asked staff about this. A care assistant told us they helped people to complete their life histories but often relied on family members to direct the level of detail they wanted. We found evidence staff had contacted the person's relatives to help them complete a personal history. In addition, staff had spent time getting to know the person and had been able to build a relationship based on understanding the person's personality, likes and dislikes. We did see staff had been able to support the preferred daily routines of people, such as having a glass of wine in the early

evening or a glass of whiskey before bed. We asked a nurse about this. They said, "People are very much at the forefront of the experience and responsibilities of staff."

We saw some people responded very well to the presence of the maintenance manager, who greeted people warmly and knew them well. We asked them about this. They said, "We're all very busy but we still have time for one-to-ones with people. Sometimes it's the little things that make a difference. Like if someone wants me to put a picture up for them, I make sure we have a chat and a laugh and it makes people feel at home."

We found that people who used the service were well dressed in clean, smart, co-ordinating clothes. Their hair was brushed and many had been to the hairdressers, including the gentlemen. Finger nails and hands were clean and well cared for and gentlemen were clean shaven (if that was their choice). Everyone we spoke with was happy that their privacy and dignity was maintained. One person said, "I've got no problem with dignity or privacy, the staff are very good."

We found staff had a good understanding of how to maintain each person's privacy and dignity. This included whether the person wished to have the window blind on their door closed at night and whether they wanted to have regular checks on them during the night. Staff had documented where they found a person often became distressed during personal care because they were used to being able to complete such tasks by themselves. To ensure they were able to provide personal care and maintain the person's dignity, staff had found they could reduce the person's anxiety by acknowledging the discomfort of having someone else provide such care and reassuring them there was nothing to worry about.

Another example of protecting people's dignity was when staff had identified one person who would take their clothes off in communal areas when they were anxious or distressed. We saw staff had been able to divert the person discreetly from the area to protect their privacy and remind them there were other people in eyesight, suggesting they went to their bedroom to remove their clothes.

The registered provider had a policy and procedure for promoting equality and diversity within the service. Discussion with the staff indicated they had received training on this subject and understood how it related to their working role. People told us that staff treated them on an equal basis and we saw that equality and diversity information such as gender, race, religion, nationality and sexual orientation were recorded in the care files. Staff also supported people to maintain relationships with family, friends and other people in the community. Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious needs but these were adequately provided for within people's own family and spiritual circles. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

People were able to move freely around the service; some required assistance and others were able to mobilise independently. We saw that people who needed equipment to help them move from place to place were spoken with by the staff before, during and after the procedure to make sure they understood what was happening at all times. One person told us, "The staff are very experienced and I have full confidence in them."

For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available in the entrance hall of the service. People told us they did not use independent mental capacity advocates (IMCA) as they were either capable of speaking up for

themselves or had a member of their family who acted in this capacity. An advocate is someone who supports a person so that their views are heard and their rights are upheld. Where people had a person acting as their Power of Attorney (POA) this was clearly recorded in their care file. A POA is a person appointed by the court or the office of the public guardian who has a legal right to make decisions within the scope of their authority (health and welfare and/or finances).

Staff spoke confidently with us about end of life care. They were able to talk about palliative care and people's needs and what this meant in practice. Staff told us they had completed training in end of life and they had found the sessions to be informative and useful. People were supported to express their wishes regarding end of life care regardless of beliefs and religion. Where people had already made funeral arrangements or expressed their end of life wishes these were clearly recorded in their care file.

We looked at the 'do not attempt resuscitation' authorisation (DNAR) for three people. We found these were in date, had been completed by an appropriate healthcare professional and included the input of an appropriate family member. All nurses at the service were trained in care and treatment for people at the end of their life, including in the use of syringe drivers for delivering pain relief. We saw that relatives had written letters of thanks to the registered manager and staff. One relative had said at the end of their loved one's life the staff had "Shown true empathy" and "Gave the family time to spend the final hours with their relative."

Good

Is the service responsive?

Our findings

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide personalised care to each individual. We asked people who used the service about their views on the care they received. People told us "I don't think it could be better" and "I am usually independent, but at the moment need some assistance, staff are more than happy to do this for me."

Assessments were undertaken to identify people's support needs and care plans were developed outlining how these needs were to be met. Each person had their own care file, which contained a number of care plans. We looked in detail at four of these files. The information recorded within this system was person centred. Records evidenced that the information had been gathered from the person themselves and their family.

In some cases we found evidence of personalised care and how it was to be implemented. For example, one person had indicated they wanted to wake up and get up at their own time, rather than adhere to a specific routine. Staff had documented this in the person's care plan and also stated the person did not appear to have a preference for male or female care assistant support during personal care. However, it was not clear whether the person had been asked about this. In another person's care plan, it was documented staff had asked the person this question and had been able to provide personal care as requested.

There were a number of sections in each person's care plan used to contribute to individualised care planning. Sections included mental health, cognition and cultural, spiritual and social values. One person's care plan recorded that staff had found from talking with them that they enjoyed debating about current affairs and philosophy. We observed staff engaged the person with such conversation during the day.

Staff completed daily progress and evaluation notes for each person. From our review of these we found staff responded quickly to people when presented with urgent situations. For example, when one person had become aggressive, staff had removed an item they could use as a weapon and had diverted the person's attention by offering them an activity to help calm them down. We saw that food and fluid charts were completed for some people; the majority were filled in appropriately, but a few had gaps in the recording. We also found that although weights were being monitored, some staff had not transferred the information from the weights book into each person's individual file.

Staff routinely asked people and their relatives if they were happy with the care provided during monthly care profile reviews. Staff used a three-monthly care profile review to involve people in care plan updates and to ensure care was delivered according to individual needs. We found staff had documented feedback from relatives, but it was not always evident this had been implemented. For example, the relative of one person had said they wanted staff to contact them more consistently when a healthcare appointment was arranged, wanted their bathroom to be cleaned more frequently and offer a better range of activities. Another relative had suggested staff offer the person an 'occupation' in the home to keep them occupied, such as helping to arrange things or with washing up. We did not find staff had implemented these at the

time of our inspection.

Each person had an activities record in their care plan, which included details of past and current hobbies and interests. One person's care plan only included details of past hobbies and interests and we did not find evidence staff had used this information to provide a specific activities programme for them. For example, we saw the person enjoyed parks and open spaces, drawing and painting and poetry. Daily records indicated staff had not offered them access to such activities and a current activity plan document had not been completed. In another care plan, staff had identified a number of interests they could support the person with, including listening to their favourite music and going to the pub.

We discussed our concerns regarding recording in the care files as outlined above with the registered manager. On the second day of our inspection we found that all issues had been addressed by the staff on duty.

Discussion with one of the activity coordinators showed that they were carrying out a survey with people who used the service to find out their likes and dislikes with regard to activities so the planned programme of events could be adapted and tailored to meet their needs. At the time of our inspection there was a monthly programme of activities on display, including cooking sessions, special lunches, singers and entertainers coming into the home, church services and the Knit and Natter group. These were in addition to the usual daily activities such as outings on the minibus, craft sessions, games, quizzes and reminiscence sessions.

One person was celebrating their birthday and they told us, "I am having a really lovely day. Everyone has been in to see me and the staff have sung 'Happy Birthday' to me." We overheard visitors and staff popping in to see this person over the whole day and giving them presents and birthday greetings. They celebrated with balloons, a card and a cake from the service.

People's religious needs were met as there were a number of church services taking place in-house including Methodist, Church of England and Baptist faiths. Representatives of other faiths such as the Catholic Church visited the service on request. Staff told us that they accompanied one person to a local church service on a regular basis.

People living with dementia had recently been provided with specific activities such as rummage boxes, which contained familiar items such as books, clothes, handbags and household items. For people accommodated on the ground floor of the building boxes of games had been added to the lounges, giving people and staff easy access to these items.

A copy of the complaints policy and procedure was seen in the lift so people and visitors were able to read this as they used the lift. We looked at the record of complaints kept by the registered manager and saw that there had been four made in the last year. These documented the issues raised, by whom and the actions of the registered manager to investigate these. We saw evidence that the registered manager gave a written response to the complainants and that their actions were appropriate and timely. People and relatives who spoke with us said they were aware of the complaints process to follow and confident of using it. One relative told us, "I go straight to the manager if I have any concerns and they sort things out immediately."

Good

Is the service well-led?

Our findings

We found the service had a welcoming and friendly atmosphere and this was confirmed by the people, relatives, visitors and staff who spoke with us. Everyone said the culture of the service was open, transparent and the service actively sought ideas and suggestions on how care and practice could be improved. People who used the service and staff told us they enjoyed being at the service and references to being part of a family were made. Staff told us they had confidence in their colleagues and there was visual evidence of good day-to-day teamwork.

There was a registered manager in post who was supported by a deputy manager and an office administrator. The registered manager monitored the quality of the service by regularly speaking with people to ensure they were happy with the service they received. People who spoke with us all knew and claimed to get on well with the registered manager. One person told us, "I get on okay with [manager], they pass by my door and they always 'pop in'."

All of the staff we spoke with described a positive working environment. A nurse told us the senior team had been able to improve working relationships by holding a group supervision session. They said, "Carers need to be very much focused on people so we need to make sure working relationships are very good. Morale here is high and we have a dedicated team; many staff have been here for years." We found a culture in which staff were encouraged to progress and apply for promotion and professional development.

A senior member of staff described a positive working culture in which staff were rewarded for their work. They said, "We've moved away from disciplinary practices towards a more empowering work atmosphere, so people can feel confident enough to take responsibility for their work." We saw documented evidence of the vision and values promoted by the registered provider. These indicated the service worked towards delivering a high quality service that reflected evidence based practice tailored to meet people's needs.

We saw that the registered manager completed a month end report for the registered provider. This showed they analysed risks within the service and reported on these to the registered provider. Monthly audits were also completed and those for January 2016 showed that any issues were recorded on action plans and were dealt with by the registered manager through staff meetings, supervisions or face to face discussions. Issues we raised during our inspection were acted on quickly and immediate action was taken to put things right.

The registered manager completed a six monthly quality assurance audit that covered all aspects of the service and we were shown the documentation for February and October 2015. The regional director carried out a two monthly visit to the service. Any issues found were recorded on an action plan and actions were signed off by the registered manager as they were completed. This demonstrated that the registered manager monitored and assessed the service on a regular basis and took action to improve staff practice and the service when concerns were identified.

Meetings with staff were held monthly and showed that care, staff practice, training and changes within the service were all discussed. Staff told us about the 'resident of the day' practice that had been discussed at

the meetings. This was where one person was chosen each day and the whole staff team focused on them. For example, the chef came out to talk to the person about their food likes and dislikes, care staff discussed their care and support with them and updated their care plan and the cleaning staff deep cleaned their bedroom. This indicated that everyone living in the service received input to their needs and their wishes and preferences were listened to at least once a month.

Feedback from people who used the service, relatives and staff was obtained through the use of satisfaction questionnaires, meetings and one to one sessions. The satisfaction questionnaire information was gathered and analysed by an independent company and given to the registered provider; where necessary, action was taken to make changes or improvements to the service. The 2015 survey report showed that 90% of people were happy living in the service and 97% were satisfied with the overall standard of care. We saw minutes that showed resident and relative meetings took place every three months. The last one was held in January 2016 and 11 people attended.

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of people using the service were not always thoroughly assessed and effectively managed and this placed people at risk of otherwise avoidable harm. Regulation 12 (2) (a) (b) The registered provider failed to protect people against the risks associated with the unsafe use and management of medicines by having inappropriate arrangements for the recording and handling of medicines. Regulation 12 (1) (2) (g)