Borough Care Ltd

Silverdale

Inspection report

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Website: www.boroughcare.org.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out over two days on the 29 February and 1 March 2016. Our visit on the 29 February was unannounced. We had brought forward this inspection following a concern regarding how the home responded to incidents and accidents.

We last inspected the home in January 2014. At that inspection we found the service was meeting all the regulations that we reviewed.

Silverdale is located in a residential area in Bredbury, Stockport, and is a purpose built two –storey home accommodating up to 47 older people most of whom have a diagnosis of a dementia type illness.

The layout of the home covers a large area and includes several communal lounges, some of which had been decorated to reflect bygone times, such as a 1950's style living room and kitchen.

People are accommodated in single bedrooms on two floors, with lift access to the upper floor. There were 42 people using the service at the time of the inspection, including one person who was there for a short period of time.

The home had a manager registered with the Care Quality Commission (CQC) who was present on both days of the inspection. A registered manager is a person who has registered with CQC 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 and associated regulations about how the service is run.

We found five breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. We found that following an injury to a person using the service medical advice was not sought, and recorded details following incidents did not provide sufficient information about the cause and consequences of incidents. The records of the administration of medication did not give us confidence that medicines were always being managed safely. We saw that when people were unable to consent to their care and treatment because they lacked capacity the service had not sought the appropriate authorisation. You can see what action we have told the provider to take at the back of the full version of the report.

People who used the service told us that they felt safe and believed there were enough staff to meet their needs. One person told us, "I know they are busy, but they will check if I am OK. If I ring my buzzer they always come quickly".

We found people were cared for by experienced staff who were safely recruited. Staffing was planned to ensure that the same staff worked in the same area of the home, which allowed for continuity of care and familiarity for people who used the service. The service was clean and tidy, with communal areas and corridors kept free from clutter to minimise the risk of accidents.

There were systems in place to ensure that people who used the service were protected from the risk of harm. Staff had received training in whistleblowing and safeguarding adults, and were able to tell us what they would do if they had any concerns about the people who used the service.

There was information in people's care records to guide staff on the care and support needs required and this included information about their likes and preferences.

People and their relatives were involved and consulted (where appropriate) about the development of their care records. This helped to make sure, wherever possible; the wishes of people who used the service were considered and planned for. The staff we spoke with had a good understanding of people's individual needs and the support they required, and we found that care was delivered consistently by a team of workers who knew how to support people and meet their assessed care needs.

We saw people had enough food and drink and there was good interaction between staff and the people who used the service at mealtimes. Specific dietary requirements such as sugar free were provided as required.

People were supported to see health professionals as and when required. One GP (General Practitioner) visited every week and there were regular visits from a visit podiatrist, optician and dentist.

The staff we spoke with had an in- depth knowledge and understanding of the needs of the people they were looking after. We saw that staff provided respectful, kindly and caring attention to people who used the service, and people told us they were given choice in how their support was delivered.

The people who used the service told us that there was enough to do during the day. Some had formed friendship groups and would seek each other's company. Care staff arranged activities such as bingo each afternoon, and would organise parties to celebrate people's birthdays.

The registered manager was held in high regard by staff and visitors to the service. The staff team had confidence in the management structure and received regular supervision. Staff worked well together and were supportive to each other as well as to the people who used the service.

To help ensure people received effective care, checks were undertaken by the management of the home and people could comment on the facilities and the quality of the care provided.

We saw that systems were in place to monitor the quality of the service provided, but these did not always identify issues of concern, such as the administration of medicine.

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.

Medical treatment was not always sought following accident or injury.

The recording of the administration and management of medication was not always carried out in a safe way.

People were protected from abuse and the staff knew and understood the whistleblowing and safeguarding procedures.

The service followed safe policies for recruitment of staff.

Is the service effective?

Requires Improvement

The service was not always effective

Consent for care and treatment was not sought in line with the mental Capacity Act 2005 (MCA).

Staff received regular supervision and attended team meetings.

Food was adequate and nutritious and special dietary needs were met.

Is the service caring?

Good

The service was caring

People were treated with kindness and compassion, and felt respected.

People were offered a choice in how their care was provided.

People's privacy was respected.

Staff and management took pride in the presentation of the people who used the service.

Is the service responsive?

Good

The service was responsive.

There were good systems in place to communicate any changes in needs.

Daily activities were available and people were supported to maintain. friendships.

Complaints were recorded and investigated.

Is the service well-led?

Requires Improvement

The service was not always well led

Systems to monitor the quality of the service did not always identify issues.

Staff and visitors had confidence in the management and showed positive regard for the registered manager.

Staff told us that they were involved in discussions about issues in service provision and we saw that they were encouraged to raise issues and take responsibility for their actions.

Silverdale

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 29 February and 1March 2016. The first day was unannounced. The inspection team consisted of two inspectors.

Prior to this inspection we received a concern about the care at the home following an injury sustained to a person who used the service. We contacted the local authority safeguarding and commissioning teams to see if they had any concerns and reviewed the previous inspection report and notifications that we had received from the service. There were no other concerns raised.

As we had brought our inspection forward we did not ask the provider to complete a Provider Information Return (PIR), prior to this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we saw how the staff interacted with people using the service. We spoke six people who used the service, but were only able to engage in conversation with three of them. We spoke with eight visitors, two of whom were visiting health professionals. We also spoke to the registered manager, the deputy manager, five support workers and one housekeeper.

We walked around the home and looked in some of the bedrooms. We looked in the communal lounge, dining room, the kitchen, laundry, the shared toilets, the shower and bathroom. We reviewed a range of records detailing people's care and support which included six people's care records, nine medicine administration charts, three staff recruitment files and training records and quality monitoring records such as auditing records about how the home was being managed.

Requires Improvement

Is the service safe?

Our findings

We were aware that concern had been expressed following an incident which resulted in injuries to a person who used the service. The service had an accident procedure which reflected good practice and gave clear instructions to inform staff how to respond to an accident or injury. We saw that this procedure was not always followed in accordance with the instructions given. We found that there had been an incident involving a person who used the service, where in line with the provider's accident/ incident policy medical advice should have been sought but wasn't.

This identified issue is a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at five case records, which showed that the service used a Risk management form to assess risks and plan care and support. When risks had been identified the corresponding care plan did not always reflect the risk, for example a care record showed that one person had lost weight. Staff said this person refused most food and drinks offered to them. The person had been weighed each month recording a weight loss of 13.3lbs between 16/01/2016 and 21/02/2016. The risk management form had been signed to show it had been reviewed, but no information was recorded regarding action being taken to manage this person's weight loss. Carers encouraged the person to eat and drink and completed a daily food and fluid chart but no care plan was in place. The registered manager told us that where there were concerns about a person's weight they had been referred to the dietician for further advice and support, and a visiting nurse told us that the service did make referrals. In this instance we did not see evidence that a doctor had been informed or that a dietician had reviewed the person.

These identified issues were in breach of regulation 12(2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service managed medicines and found several medicines had not been given as prescribed. We looked at nine medicine administration records (MAR). In one we saw that a person had not received one particular medicine on two consecutive days. On the first day the record was left blank, and on the second day the letter 'S' was entered. This was not a code listed on the MAR. A carer told us it was used to indicate that a person was sleeping and therefore had not been offered the medicine. The same person had not received further prescribed medicines around the same time, and the omissions were not explained on the reverse of the MAR.
We also found that some people were prescribed medicines to be taken as required or 'PRN' e.g. paracetamol. We checked the count of these PRN medicines for 4 people. No entry had been made on the MAR for an amount supplied or brought forward so it was not possible to determine if the correct number of tablets remained.

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

The system in place for ordering medicines was lengthy and the Deputy Manager told us that although they requested the next month's supply a week after the current month's medicines had been commenced, it could take until the Friday before the next 4 week 'month' period began, before the medicines were delivered. This meant it would be too late to rectify any shortfalls or mistakes before the new medicines were due to commence on the following Monday.

Following our inspection the Provider confirmed that an internal investigation had been undertaken to investigate the recording of the administration and management of medication issues identified. The Provider also confirmed that a review of the medication systems in place at the home was to be completed to identify and address issues within the service/ GP surgery and pharmacy.

The MAR charts we analysed all included photographs of people to help staff identify them and listed any allergies. They also contained a list of names, signatures and initials of senior carers who had received training to administer medicines. This allows any audit trail to determine who had administered the medication and signed the MAR. Senior carers had received training to administer medicines.

We saw medicines were stored securely and, when no longer required, recorded and safely returned to the dispensing chemist. Appropriate temperature checks took place to ensure the medicines stored in the room and fridge was maintained at a safe temperature.

The home used a system where regular medicines were prepacked in blister packs for each individual, by the dispensing chemist. The carer checked the MAR before putting each tablet into a medicine container. They were patient and gentle with people and stayed with them until they had taken medicines before signing the medication administration records (MAR).We saw they supported people to use inhalers appropriately and safely administered eye drops.

One person refused their medicine and the carer left them and returned later when the person happily took it.

Some people had been prescribed topical creams or lotions. We later saw these were signed for on topical medication charts kept in people's care records. The charts used a body map to indicate where each cream should be applied and included directions for use.

Two people received medicines covertly. This is when a person refuses medication and lacks the capacity to make a decision about medication. The service had acted following an assessment by the person's doctor. We saw a detailed list of medications to be given covertly and how they should be prepared for one person.

Controlled drugs (CDs) are medicines named under The Misuse of Drugs legislation. The Misuse of Drugs Regulations 2001 and 2006 restricts how such medicines are stored and recorded. The home used some of these prescribed medicines and we saw they were stored and recorded safely. Two senior carers checked the MAR and prepared the medicine before administering it. They signed the register and MAR only after the medicine had been taken.

A person who lived in the home said they felt safe and that it was, "Pretty good." They said, "The staff are all nice, I don't need much help but they are with me for showers and when I need them." They said staff were often busy but always came quickly when they used the call buzzer and, "In an emergency they are here in seconds."

The layout of the home covered a large area and included several communal areas, on both floors. People

chose to sit in different areas during the day. Some people remained in their bedrooms for all or part of the day, but were free to wander around the home. When they were not involved in other duties we saw staff would spend time sitting in lounges with people responding to people's needs. Call alarms sounded infrequently and were promptly responded to. When we visited, the atmosphere was calm and unhurried.

The whistleblowing policy was available in the staff office, and we were shown a copy of the safeguarding adult's procedures which provide guidance to the staff on their responsibilities to protect vulnerable adults from abuse. Staff told us that they were aware of these procedures and understood how to safeguard people from different types of potential abuse. They all said they had received training about this and discussed with us the signs that would alert them to potential abuse and the actions they would take. During discussion staff demonstrated to us that they knew what to do if they witnessed or were informed of a concern about an individual's safety. One staff member told us "If I see or hear anything I would go straight to the manager." This person went on to recount an incident where they were concerned about the treatment given to a person who used the service, and described how their actions were followed by the provider and subsequent protective measures put in place. They explained how this had increased their confidence to ensure that appropriate action would be taken to prevent abuse. We saw that the home investigated allegations of abuse and protective measures were put in place to minimise the risk of harm.

The registered manager said staffing was planned so the same staff worked in the same area of the home each day, whenever possible. This allowed for continuity of care. Staff we spoke with confirmed this which meant people benefitted from being cared for by staff who knew them well.

There were clear recruitment procedures in place to help ensure that new staff were of good character to provide care to vulnerable adults. The procedures were in line with regulations. We looked at information stored on three members of staff, and saw that application forms included previous work history and satisfactory references were sought prior to new staff starting work at the home. Further checks through the Disclosure and Barring Service (DBS) ensured that there were no criminal convictions; proof of identity was provided, such as birth certificates, and national insurance numbers noted. We saw that interview notes were also taken and stored securely.

People who used the service told us that they believed there were enough staff to meet their needs. One person told us, "There is always someone hovering around. I know they are busy, but they will check if I am OK. If I ring my buzzer they always come quickly". A visitor said that while they always had to "Go and find someone, it was always easy to find a member of staff".

In addition to the registered manager and deputy there were normally eight staff on duty during the day, seven staff in the evenings and three waking night staff. The home also employed a number of domestic staff. The layout of the building with long corridors and numerous lounges made supervision of residents difficult, particularly those who would wander. One carer said they thought an extra carer was needed in the afternoon on the ground floor when people living in the home required increased support and care.

Two carers we spoke to said it was very busy in the morning and could be "Difficult to keep an eye on everyone," when carers were working in pairs to support people in their bedrooms. One said they would like to have more time to spend talking with people and facilitating activities. While our observations confirmed enough staff to meet the general needs of the people who used the service, the size and layout of the building meant that staff did need to be vigilant, especially given that most of the people who used the service were living with dementia.

Carers told us they were asked to work extra hours sometimes to cover sickness or annual leave. Last minute

absences were sometimes filled by the manager or deputy. Staff said agency staff were sometimes used. We looked at the staff rotas for the three weeks prior to our inspection and these showed that there were no vacancies for care staff, but some sickness had been covered either by agency staff or regular staff who worked on overtime.

People told us that the home was always clean and tidy. We checked the kitchen and saw that it was clean. A Food Standards Agency 'Food Hygiene' rating showed the highest rating of 5. We saw that Fridge temperatures were monitored and recorded to ensure food was stored correctly, and that there was a temperature probe to ensure hot food was served at the right temperature.

When we walked around the building we checked the service had systems in place to protect people and staff from infection and cross infection. In the laundry we saw that soiled items were appropriately washed separately from other items of clothing, preventing the risk of cross contamination.

We saw that hazardous items such as cleaning materials were stored safely when not in use. However, a kitchen on the ground floor that staff told us was used by relatives to make drinks was unsecured. This might present a risk of scalding to people living at the home. A second kitchen on the first floor was locked.

There were two staircases. One was secured at the top and bottom with a keypad lock. The other was unsecured. We saw a person who lived at the home walking up the staircase using a walking stick. The manager did not think people were at risk of falling on the staircase but it was unclear if all people living at the home had been assessed for this risk. When we spoke to the registered manager about this she agreed to review the risk and would bring in appropriate measures to minimise the risk.

We noticed one bedroom had a strong malodour, which may have been emanating from under the laminate flooring. This had been reported by the registered manager to the provider and the Quality Control Manager agreed to complete a deep clean and if required would re-floor the room.

We saw that the majority of toilets had posters detailing safe hand washing techniques, and that liquid soap; paper towels, disposable aprons and hand gel were available, further reducing the risk of cross contamination.

Staff we spoke to had completed an e-learning course on infection control and understood the importance of infection control measures, and the use of personal protective equipment such as tabards, vinyl gloves and other protective measures when handling food or completing personal care tasks and cleaning. Wearing such personal protective clothing protects staff and people using the service from the risk of cross infection during the delivery of care. Cleaning equipment such as mops and buckets were colour coded so different ones were used in the kitchen areas, bathrooms and laundry areas. A recent infection control inspection carried out by the local authority Health Protection Nurse indicated no major concerns.

Communal areas and corridors were kept free of any clutter to minimise the risk of accidents, and health and safety risk assessments and checks for the building and equipment had been completed and were up-to-date.

We saw that the fire alarm was tested every week and that fire extinguishers servicing history was up to date, and a personal evacuation escape plan (PEEP) had been written for all the people using the service. These plans explain how a person is to be evacuated from a building in the event of an emergency evacuation and take into consideration a person's individual mobility and support needs.

We looked at maintenance records and safety certificates which were all in order. We saw that regular maintenance safety checks were made on safety equipment, such as the fire alarm, smoke detectors and emergency lighting. The registered manager completed a record of any maintenance jobs which were needed and would pass this to the maintenance team. Other equipment used to support care staff with people's personal care, such as hoists, were regularly serviced to ensure safe operation. We were informed that one senior worker had been given responsibility for checking on a weekly basis that wheelchairs were in working order, clean and usable.

Requires Improvement

Is the service effective?

Our findings

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We checked whether the service was working within the principles of The Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The 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.

We asked four carers about their understanding of the requirements of The Mental Capacity Act and how it affected people living with dementia in the home. Three had had training in dementia care and mental capacity. One said they had not received any training about it or about caring for people with dementia, but thought it was planned.

Staff also said it would be unsafe to let anyone out alone and were not sure who had a DoLS in place. Only one senior carer seemed to understand the implications of a DoLS on a person's life and knew who and why people had DoLS. This carer was able to discuss advocacy, power of attorney and the need for best interest meetings to make decisions when people lacked capacity to make their own.

Where it was apparent that the individuals were clearly demonstrating an objection to their care and treatment, for example, by attempting to leave the premises, the registered manager had submitted DoLS applications to the local authority. We saw, however that there were people using the service who were living with dementia and did not have the capacity to either consent or object to their treatment, and would therefore be subject to deprivation of liberty safeguards. These had not been put in place. For example, we found one person was supported for most of the day in a 'bucket' chair which severely restricted their movement. Whilst this person was showing no visible signs of objection, there was no evidence that she had consented to this restriction on her movement, or that other less restrictive options had been considered.

Care files contained consent forms, for care and photography and bedrails. Two that we saw had been signed by a relative but we did not see evidence the two people lacked capacity to make their own decisions or to consent on their own behalf.

This was a breach of Regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with believed that the carers were competent and knowledgeable. One person said, "They know how to look after us and make sure we are cared for." A visiting relative told us that staff

understood their family member, and how best to respond to their needs. This person said "they want to know her, so they can meet her needs. They understand how to respond to her moods, and will support her just as much as she needs". They thought this was due to a calm and patient approach of the staff who had a good knowledge of people living with dementia.

We asked the staff that we spoke with what training they had received in order to carry out their role. They told us that when they began working at Silverdale they had an induction to their role where they received on the job training, and shadowed more experienced workers. In addition to this they were asked to work through a computer based learning package. All staff had access to e-learning through a training package which taught a variety of topics, including care and support; fire safety; health and safety; infection control and food hygiene. In addition they had completed a variety of training courses including Safeguarding Adults, Infection Control, and Moving and Handling.

Some staff told us that they had had some basic dementia training but given that the majority of the people who used the service were living with dementia they were keen to learn more. When we spoke to the registered manager about this she informed us that the provider had recognised this need and had developed a strategy called "Enter My World" to support people living with dementia. This included a six week training course which some staff had already attended, and the service had further plans to bring in a trainer who would observe interactions within the home and develop a bespoke training package for staff, based on the needs of the people using the service.

The care staff we spoke with told us they received regular supervision meetings with a line manager. We saw records which showed that staff received supervision every eight weeks. The registered manager supervised the deputy manager and housekeeper, whilst other senior staff were supervised by the deputy manager. Care staff were supervised by their senior carer. The provider had recently introduced a system for yearly appraisal for all staff, and the registered manager informed us that training was in place for all senior staff to ensure a consistent approach to supervision and appraisal.

Food was prepared at the home by an independent company and people living at the home were assisted to order their meals a week in advance. A person we spoke with said they were used to it now, that the food was, "Up and down but not a cause for complaint". For breakfast people were offered porridge, cereal and toast and a cooked breakfast was available on alternate days. The main meal of the day was served at lunchtime, and a smaller tea - sandwiches or a filled jacket potato - was served in the early evening. Supper was also available and on the first day of our inspection people were offered pancakes, which were very well received.

There were several dining areas around the home and some people chose to eat in their bedrooms. We observed lunch service in both the first floor dining room and on the ground floor, where most meals were taken in the main dining area. Some people chose to eat together in a smaller and quieter lounge. The tables were set with tablecloths, and people were helped to take a seat by the carers. Cold drinks were served, either water or orange squash. Carers asked people if they wanted to wear an 'apron' before helping them put one on to protect their clothes. Food was served from a heated trolley and although people had ordered in advance, they were offered an alternative if they did not want the ordered meal.

There was a choice of main course, but most people on the first day of our inspection had chosen hotpot. There was only one choice for pudding but the carers told us they could get fruit or yoghurt from the kitchen if needed.

Staff were aware of people's dietary needs. Specific dietary requirements such as "sugar free," were

available as required, and a list of any special diets was kept in the kitchen where the specific meal would be plated up before being served to the right person.

The food smelt appetising, and was well presented. The atmosphere was pleasant with appropriate music in the background. Care staff observed and assisted when needed. We saw good interaction between staff and the people who used the service. When one person enjoyed their meal and finished it quickly, carers offered a second helping which was accepted.

During this time another carer took meals on trays to people in their bedrooms. We saw they tried both different meal options for a person who had refused food. They also offered snacks such as crisps, yoghurt and sandwiches.

The care files we looked at showed that attention was given to people's nutritional needs. Nutritional assessments had been completed and where necessary food and fluid charts were kept to monitor the amount of food and drink people were taking.

Each new admission was assessed prior to moving in the home. We saw in care records we examined that these plans included assessments from other health and social care professionals.

People told us and we saw documentation in care files to confirm that people were supported to see other health professionals when required. The home had a good relationship with district nurses who visited on a daily basis. The registered manager informed us that all people who used the service were registered with one of two general practitioners (GP). One GP visited the home each week, whilst the second – who had fewer patients – would ring weekly. This helped with communication and to gain a better knowledge of the people who lived there. Both would visit if a person who used the service was poorly. The service used an optician who completed six monthly visits, but would also come out as required, and a podiatrist visited every 6-8 weeks.

One visiting professional told us that the staff were good at responding to health care needs. They informed us that the staff were competent and knowledgeable about issues such as pressure care and dietary needs, for example, they will seek support at the first sign of pressure sores developing which helps to minimise the risk of deterioration. This person told us that if she were considering a home for a relative it would "Definitely be on my shortlist."

The layout of the home could be confusing, with long corridors some of which lead on to other areas, and some came to a dead end. There were two enclosed yards, which were not used by the people who used the service or overlooked from bedrooms, but we noticed one was littered and untidy. We asked the registered manager to arrange for this to be tidied as it created an impression of a lack of care and consideration for the people who used the service. Following our inspection the provider confirmed that the yard had been tidied and decorated with flowering baskets.

Communal areas were clear and allowed for social interaction, with smaller areas available for entertaining visitors or privacy. Rooms were well decorated and bedrooms were personalised according to individual's tastes, were bright, clean and well maintained. Toilet and bathroom doors had clear dementia friendly signs to make them easier for people to find. Bathrooms and showers were spacious and equipped to allow people to be supported as necessary when receiving personal care.

Areas of the home had been adapted to create interest and stimulate reminiscence. This included a corner displaying First World War memorabilia; an area where sewing and needlecraft items were displayed and a

large kitchen/living area in 1950's style. A room on the first floor had been converted into a 'Namaste' room. This is a sensory room which had been decorated in calming pastel shades, with low lighting and aesthetic decorations. This provided a relaxing and calm atmosphere offering people who use the service peace and quiet. We were informed by staff that people can use this room when they are anxious, or staff will provide 1:1 support in this room when people display difficult behaviours which might put themselves or others at risk.

Good

Is the service caring?

Our findings

People who used the service told us that they were well cared for. We spoke to one person who said "we can have a laugh with the staff; they are all very kind and nice. They respect me. You speak to them and they respond. I have no complaints, everything is fine". We saw that people were supported by caring and competent staff who understood their individual needs. A visiting relative told us "The staff are brilliant; all of them are so friendly and interested. They want to know about [my relative] and they make sure she has all she needs". Another visitor said the staff were very good and very helpful and, "From what we've seen they are all genuine and caring."

Throughout our visit we saw carers interacted with people in a friendly and positive way. It was clear staff knew people well from the way they spoke with them, using humour when appropriate. When we spoke to staff members they showed an understanding of the people they supported and their individual preferences. People who were unable to express a view appeared calm and comfortable with the staff who assisted them.

Relatives we spoke to also told us that they were made welcome when visiting the home. They informed us, and we saw that staff knew them and addressed them by their preferred name and were always welcoming. There were no restrictions placed on visiting times. One visitor told us that their relative "Always looked lovely, even though they never knew when we were coming".

People who used the service told us that they thought the care staff made an effort to get to know them. Staff agreed that this was important and spoke affectionately about the people they supported in a way that demonstrated concern and enthusiasm. One carer said, "I love working here. No day is the same." Another said, the atmosphere was really good, "Especially when there is time to talk to people, even just about the weather or we have a sing-song." Another told us the best thing about working at the home was the people who used the service, "It makes me happy to see people well looked after."

We observed staff treat people in a caring and compassionate manner. For example, we saw one care worker offer to take a person living with dementia to join in an activity. When this person responded in a negative way and became aggressive, the care worker helped to sooth the person, speaking in a calm and relaxing manner and offering alternative activities. They gently took the person by the arm and offered to find something else for them to do. We also overheard a care worker talking quietly to a person becoming anxious and the care worker provided reassurance, then they shared a joke together before the care worker escorted the person "Off for a nice cup of tea". When we observed lunch we saw that staff offered to help anyone struggling to eat their food, and allowed people the time to finish their meals without rushing to clear tables.

People and their representatives told us that they were offered choice in the delivery of their care and support. A carer said people had choices about every aspect of their day in the home, from when to get up in the morning, what to wear, what to eat, to when to go to bed at night. Another said when people chose to spend the day in their bedrooms, they were given a choice on whether the door was left open or closed to

provide privacy.

We observed that one person who used the service had an appointment with the visiting hairdresser shortly before lunch. Becoming anxious, this person explained to a member of staff that she was worried that they might miss lunch. The care worker explained nicely that this was unlikely but offered a later appointment or to keep her lunch warm. The person chose the latter, and the meal was kept warm.

People and their representatives were encouraged to discuss their needs and how they might like them to be met. One visitor told us that even though their relative had been admitted "Rather quickly and in an emergency" the staff involved them in planning the care and took time to get to know the person.

The provider had set up a new system for managing information about individuals using a person centred approach to care planning, called 'True person centred care'. The aim was to place the individual at the centre of their care planning and we saw evidence that peoples wishes were taken into consideration in planning their care. We were told that senior care staff would review care packages on a monthly basis with individuals on a one to one basis. One person who used the service told us that they would "Often sit me down in my room and talk to me about what I might need, and ask me if I'm alright."

Although in its infancy and part of an ongoing process of change from a more task centred approach to delivering care, we saw that staff were building up information about individuals. For example, following a conversation with a person who used the service and their relative a care worker discovered information about the particular tastes of the person, and arranged for the particular dish to be provided at tea or supper.

The diligence and vigilance of staff reflected a person focussed delivery of care but this was not reflected in some of the older documents still in use. These contained information which was not always written in a person centred manner, for example, handover sheets and some incident forms referred to the room number rather than the individual. This has an effect of de-personalising the individual and risks a loss of individual identity. When we spoke to the registered manager about this she recognised that services had been very task orientated and was reviewing the documents to reflect the delivery of care.

Carers told us they had received training about end of life care and there was evidence that people's wishes for their end of life care had been considered. On admission, people and their representatives were given the opportunity to make any advanced decisions (these are decisions made to refuse specific types of treatment in the future) and discuss their wishes. This was documented in case records. Information provided included personal preferences, such as funeral plans where appropriate. The service had appointed two senior members of staff to take responsibility for co-ordinating end of life care, and would regularly meet with the specialist nurses, and if people were approaching end of life, sensitively discuss their wishes, advocating with doctors for example, when discussing DNAR requests. A DNAR (do not attempt resuscitation) form is a document issued and signed by a doctor, which advises medical teams not to attempt cardiopulmonary resuscitation.

Good

Is the service responsive?

Our findings

We reviewed care files for five people. These included a pre-admission assessment. Person centred information, including preferences and dislikes was recorded on a form titled 'True Person Centred Care'. Parts of this system were good and promoted a positive response, for example, sections marked "morning routines" would instruct staff on the needs and wishes of individuals at different times of the day, but the focus of plans remained task orientated, and the information held about people appeared to be of limited value. For example one record noted that a person had been a keen gardener, but no attempts had been made to encourage him to continue this interest.

We saw evidence in a one person's care file that the person had agreed to, and signed their care plan. In other files where a person was unable to consent a relative had signed on their behalf.

People told us that the staff responded to their needs. One person told us "I try to do as much as I can and they encourage me: you speak to them and they respond. They let me help out sometimes; I don't like to see them having to do all the work".

A visitor told us their friend had, "massively improved" since coming to live at the home. They said they had not been eating properly and had not been communicating with them. Since moving to the home they were eating and drinking regularly and responded to questions. They said they had asked carers about "Getting her nails cut the other day" and they had responded quickly. We were told by relatives that the staff would keep them informed if their relative was unwell.
Another visitor told us that their relative "Was not the easiest person, and would say if unhappy, but whenever I came to see her she would always say how happy she was. She was fine and she loved it". Of the staff: "They are the best without a doubt!"

Handovers help to ensure that staff are given an update on a person's condition and should ensure that any change has been properly communicated and understood. We were told that handover meetings between the staff were undertaken on every shift and carers told us they always knew about changes in people's needs from handovers. We observed one handover meeting for the morning shift. Information was passed verbally and a record kept for each unit in a separate file. This included some detailed instruction, for example "Needs prompting with personal care, encourage to brush teeth", and information such as "enjoys a bath every day".
If there were changes to the person's care plan these were highlighted to allow all staff to respond appropriately to the changing need and check the revised care plans. The service also used "Interim care plans" which allowed any short term changes in care, such as illness or dietary needs, to be logged and addressed.

The service did not have a dedicated activities co-ordinator, although the registered manager told us that the provider had begun a process to recruit to this post. Carers told us they arranged different activities for about 45 minutes on the ground floor each day, and an activity rota was on display which detailed the

events for the week and the named carer responsible for organising the event. Carers helped people from the upper floor to go downstairs to attend. Carers we spoke with talked enthusiastically about the activities people enjoyed. One carer told us they had previously raised funds in order to take people outside the home, to the seaside.

Activities were planned and recorded in a folder and some in individual daily progress reports. Planned activities included, bingo, films, board games, music and singing and manicures. In the summer, staff said, people enjoyed spending time in the gardens. People's Birthday's had been celebrated with an afternoon party.
We observed a lively bingo session which a number of the people who used the service took part in, and enjoyed. All entrants won a small token prize.
We saw a number of friendship groups, and people who used the service would seek each other out and spend time in their company. One person told us "It's my home, I've got friends here. We all get on".

People understood who they could go to if they had a complaint or were unhappy about something. One person said, "If I see something wrong I jump straight to the manager, and I have told her what's what! She listens and sorts it out"

Relatives we spoke with knew how to make a complaint and one person told us that they could complain anonymously using an on-line form. When we visited we looked at the complaints log which showed that complains had been investigated and reached an outcome. There were no outstanding complaints, with the most recent three months prior to our inspection. We contacted the local authority safeguarding and commissioning teams prior to our visit and no concerns were raised by them about the care and support people received. In the staff room we saw thankyou cards; one praised the staff for "Excellent care, kindness and patience".

Requires Improvement

Is the service well-led?

Our findings

It is a requirement under The Health and Social Care Act that the manager of a service like Silverdale is registered with the Care Quality Commission. When we visited the home had a registered manager who has been registered since March 2015. The registered manager was present throughout the inspection.

We asked the registered manager to tell us what systems were in place to monitor the quality of the service to ensure people received safe and effective care. We were told that regular audits/checks were undertaken on all aspects of the running of the service. The Provider's Quality and Compliance Manager carried out reviews of the home on a six monthly basis. We looked at the most recent audit carried out in September 2015. This showed no major concerns but recommended improvements and areas for development which had been formulated into an action plan to improve the quality of the service. Most of these actions had been implemented and where structural alterations were required, such as replacing flooring, action was in progress.

However the systems in place to review and audit the quality of care had not identified the issues we saw during our inspection, such as the recording of the administration of medication and that care plans did not always reflect identified risk.

We looked at the service's procedures for managing injuries. These stated that when an accident or injury occurs documents must record, "Where the injured person was found and in what position". When we looked at accident details the information did not always describe this. For example we saw evidence to show that where people had fallen the records did not provide sufficient information on the cause and consequence of the falls, nor were there always body maps to show the location of any injuries.

These identified issues are a breach of regulation 17 (1) (2) (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A carer said the registered manager "Is lovely, very nice and approachable, I could tell her anything." Another made similar comments and added, "I can ring [the registered manager] at home for advice anytime."

Care staff told us, and we saw the registered manager and the deputy manager were visible around the home every day when they were on duty. They showed a clear understanding of the role and responsibilities of the management team, and were aware of their responsibility to pass on any concerns about the care being provided. The manager told us information was passed up as well as down, and staff would inform her of any concerns or issues, and write these down to prompt any follow up action.

The staff we had discussions with spoke positively about working at the home. One member of staff told us Silverdale "is a happy environment. Work is satisfying – frustrating sometimes – but OK overall. The residents are our first priority and we ensure that they are cared for. We all get on together, there are no cliques and we get on fine. It's teamwork, no-one is frightened of asking for help or support across the units and we all need to help each other. People who live here can be difficult and we can all have challenging days, so we

respect and support one another". We saw that staff were supportive and accommodating to each other.

The manager told us her aim was "making residents safe and looked after. I want to make sure relatives can come here and see they are looked after. I love showing people round". This echoed the views of a relative we had spoken to, who told us that their relative "Had always said not to put me in a home but was so grateful. She loves it here. She always looks well".

The registered manager recognised that improvements could be made and had considered how to drive these forward. For example, she understood the need to be more person centred and had encouraged senior care staff to take the lead on person centred planning, which allowed them to consider and reflect on how they approached their work, and take ownership and greater pride in their work.

Senior carers would review support plans on a monthly basis and the registered manager audited these to ensure that appropriate action had been taken. She also conducted a daily 'walk around' of the building to ensure that standards were kept high, and to pick up on any issues which may require attention not picked up by the team leaders or housekeeper.

Staff told us that they were involved in discussions regarding service provision during team meetings. Staff meetings took place each month and carers said they felt able to raise issues or concerns. Minutes demonstrated that staff were encouraged to raise issues and take responsibility where mistakes had been made. Staff told us they found team meetings useful, and felt supported to raise issues and suggest changes they felt needed to be made. Staff meetings are a valuable means of motivating staff and making them feel involved in the running of a service. Individual staff members were encouraged to consider innovative ways of improving the service, and where possible these were implemented. For example, to convert a little used lounge into the 'Nameste' sensory room was an initiative from one member of staff, and once the idea was approved this person helped to design and set up the room. Another care worker told us that ideas were encouraged through the provider's staff support group which met on a regular basis.

The manager was aware of the importance of maintaining regular contact with people using the service and their families. We asked how they sought feedback from the relatives of people who used the service. We were told relatives meetings were advertised and relatives were invited to attend in order to feedback and share information about the home. In addition the manager operated an open door policy and was available to privately discuss issues with relatives or people using the service. The manager told us that feedback was welcomed and used to review and improve the quality of service.

We checked our records before the inspection and saw that accidents or incidents that CQC needed to be informed about had been notified to us by the manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent for care and treatment was not sought in line with the Mental Capacity Act 2005 (MCA). Regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medical advice following injuries was not always sought, regulation 12(1). Care plans did not always reflect identified risk, Regulation 12 (2) (b). People were not protected against the risks associated with the safe administration and management of medicines. Regulation 12 (2) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to review care did not identify issues of concern and insufficient detail recorded following accident or injury Regulation 17(1) (2) (b) (c)