Frome Care Village Limited

Frome Care Village

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 28 February and 01 March 2017 and was unannounced.

Frome Care Village provides nursing and residential care to people who are living with dementia and people who have nursing care needs. There are two parts of the village one part being The Parsonage which is divided into three "houses" each supporting people who are living with dementia and are at differing stages of their illness. The other part of the home is called Woodlands and supports older people who have care needs because of physical disability and needs which can be associated with old age. At the time of our inspection there were 50 people living in the home. The home is registered to provide care and support to 60 people. There was a registered manager. 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.

There was differing understanding from staff about their responsibilities to report any concerns about possible abuse. Two members of staff which included a senior member of staff did not understand that incidents of aggressive behaviour, which may occur and could be viewed as abuse, should be reported to the local safeguarding team for investigation.

We identified two incidents which whilst incident reports had been completed had not been referred to the local authority safeguarding team or the commission. These two incidents were referred to the local authority safeguarding team at the time of the inspection. They judged the incidents did not warrant further investigation and that there were no ongoing concerns about the health and welfare of the people concerned. This decision reflected the actions taken by the provider.

There were failures to ensure the arrangements for the administering of covert medicines were safe and ensured people received their medicines in a way that was effective. Covert is where people receive medicines disguised in food or drink. There was no clear instructions and agreement about how medicines were to be administered in these circumstances.

There were administering errors in that records of administration of medicines had not been completed. This had included a medicine that required a signature from the staff member administering the medicine.

Arrangements for the use of slings (these are used to help move people when needing a hoist) did not ensure the risk of cross infection was alleviated in that there was a risk slings could be used for more than one person.

The arrangements for the monitoring of the quality of the service were not always effective in identifying areas for improvement.

People told us they felt safe living in the home and how they were confident about the skills of care staff. Staff were benefitting from training which looked at the values around how care for people living with dementia was to be provided.

People told us they were satisfied with the availability of staff. One person told us "I feel safe with them (staff) around all the time." Staff said how they felt there was sufficient staff on duty and able to respond to people's needs in a timely way. We observed staff being available and responding promptly to people.

Staff had received training specific to supporting people living with dementia. This had led to staff commenting how their confidence had improved and having a greater understanding of the needs of people living with dementia.

The registered manager had, as required, made applications under the Mental Capacity Act 2005 and obtained authorisations under Deprivation of Liberty Safeguards (DoLS) arrangements. Where people lacked capacity their rights were upheld and their health and welfare protected.

We identified a number of improvements since the last inspection. Healthcare professionals we spoke with were positive about the care provided by the service. People had access to community health services and their GPs when this was requested. There were good relationships with outside professionals and people had access to specialist support and advice.

The service ensured people's nutritional needs were met and took action to address any concerns about people's physical wellbeing and ensure they were able to have a healthy diet suited to their needs.

People spoke of respectful staff who recognised their right to privacy and upheld their dignity. We observed how staff responded to people's anxieties and distress in a calm, thoughtful and sensitive way. People and relatives spoke of staff as being "Caring and kind." and "Treating my relative with respect."

We observed staff using touch as a way, when appropriate, to comfort and re-assure people. Staff demonstrated an ability to support people in a caring and sensitive way and were accepting of people's behaviour.

We observed positive interaction between staff and people living in the home. There was a relaxed and warm environment. People and their relatives told us visitors could visit at any time. One relative told us "We are welcome to visit any time."

People felt able to voice their views or concerns about the service. One person said, "I have never had to make a complaint but would if I needed to. I am sure they would listen and do something about it." The service was open to receiving comments and taking action where this was needed to improve the quality of care.

Care planning and approach of staff reflected person centred care. Staff recognised individual needs, choices and wishes and care was based on those needs. There was a respect for people's routines and preferences.

The registered manager promoted an open inclusive environment where people and staff felt able to voice their views.

The environment and culture of the home resulted in people and staff being able to feel involved and valued

as individuals and staff. There was an environment enabling people to receive a service which recognised their needs.

We found a breach of the Health and Social Care Act 2008. You can see what action we told the provider to take at the back of the full version of the report .

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 consistently safe

People did not benefit from staff who all understood their responsibilities to report potential abuse.

People's health and welfare was potentially placed at risk because administration of some medicines was not robust.

People were supported by staff who had received pre-employment checks to ensure they were suitable for the role.

Risks to people were identified and assessments were in place to reduce the risks.

Is the service effective?

Good

The service was effective

People rights were upheld and health and welfare protected.

Staff acted in people's best interests where people were unable to make decisions for themselves.

People benefitted from having their nutritional needs met effectively.

People had access to community based health services to ensure their health needs were met.

Is the service caring?

Good

The service was caring.

People were cared for by kind, thoughtful and friendly staff.

People were responded to by staff in a respectful and dignified manner.

People were able and supported to make choices and decisions about their daily routines.

Care staff responded to people's at times distressed behaviour in a compassionate and warm manner.

Is the service responsive?

Good

The service was responsive

People benefitted from activities which were tailored to their specific interests.

People received care which was centred on them as individuals.

People and relatives were able voice their views and make a complaint and be listened to if they were unhappy about the quality of care.

People had the opportunity to be involved in the arrangements for the providing of their care.

People and their relatives felt able to raise concerns with the registered manager and staff.

Is the service well-led?

Requires Improvement

The service was not always well led

Quality assurance systems were not always robust and effective in identifying areas for improvement.

People and staff benefitted from an open and inclusive environment.

There was a culture which centred on providing individualised and caring care recognising the needs of all the people living in the home.

Frome Care Village

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 28 February and 01 March 2017 and was unannounced. This meant the provider did not know we were going to carry out an inspection on the day. The inspection was carried out by one adult social care inspector, one specialist advisor with a nursing background and one Expert-by-Experience (ExE). An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. During this inspection, we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us. We undertook general observations in communal areas and during mealtimes.

During the inspection, we spoke with 11 people who lived at Frome Care Village, five relatives, 14 staff which included two registered nurses, We observed care and support in communal areas and looked in the kitchen, bathrooms, lavatories and some bedrooms after obtaining people's permission. We reviewed a range of records about people's care and how the home was managed. We looked at care records for six people, recruitment, training and induction records for five staff, people's medicines records, staffing rosters, staff meeting minutes and quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in Frome Care Village. One person said, "I feel safe here because staff are around to help me when I need help." Another person said, "I am safe because I can trust the staff." A relative told us "I do not have to worry about (Name)." Another relative had commented to the home "I have never been concerned about (name) safety. After visiting I always feel confident that the staff are skilled to keep her safe."

Staff told us they had completed training and knew how to recognise abuse and this was confirmed by records. However, there were inconsistencies in staff understanding. Two staff members told us if two people living with dementia hit each other this was not abuse and would therefore not require a safeguarding alert to the local authority. Such incidents are classified as abuse. These alerts are investigated by the local authority safeguarding team to establish any concerns and actions the provider needs to take to alleviate the risk of incidents and protect people from harm.

The provider had made a number of referrals to the local safeguarding team. All had been subject to investigation. None had identified any concerns as to the care and support people were being provided with to ensure their safety and wellbeing. They reflected how the provider supported some people who because of their dementia could be verbally or physically aggressive towards others. However, two incidents which met this criteria had not been referred to the local safeguarding team. This meant there was potential for incidents to occur which were not subject to this external investigation to identify any concerns as to the person's safety and well- being. These two incidents were referred to the local authority safeguarding team at the time of the inspection. They judged the incidents did not warrant further investigation, that there were no ongoing concerns about the health and welfare of the people concerned. This decision by the local authority safeguarding team reflected the actions taken by the provider.

Medicines were not always managed safely. The management of people who were receiving their medicines covertly was inconsistent and did not follow the provider's own Medicines Management policy. Covert medicine administration is when medicines are "disguised" in food or drink. We looked at the records of two people who were having their medicines administered covertly. All necessary documentation was in place in relation to how the decision to administer covertly had been reached, and there was evidence of multi-disciplinary team involvement in that decision. However, there was no information in relation to how the medicines should be administered to people. The nurse on duty said the medicines for both people were crushed and put in food, but this was not clearly documented on the Medicines Administration Records (MARs). In addition, one person was prescribed one medicine at night, and the instructions on the administration record were "Do not chew or crush". Within the medicines care plan for this person, it had been documented "Usually has medicine disguised in food such as custard/yoghurt". There was nothing documented to indicate that tablets should not be crushed. The care plan for the other person referred to medicines being given covertly, but did not detail how this should be done. This meant there was a risk that staff were crushing medicines that should not be crushed, which could in turn alter the way the medicines worked. In addition, there was a risk staff would not know that some of the tablets needed to be crushed

prior to administration because this had not been documented. We were subsequently advised by the provider new arrangements had been put in place in relation to the administering of covert medicines.

On the Parsonage unit, all of the MARs had been completed in full. There were no gaps on any of the charts which indicated that people received their medicines as prescribed. On the Woodlands unit, we noted one gap on one chart. The chart had not been signed on 27/02/2017 for a medicine that had been prescribed to be administered at 19.00 hours. We noted this missing signature on 01/03/2017 at approximately 09.45 hrs. The medicine had been prescribed four times a day, which meant the person had subsequently received five further doses, which had all been signed for. There was nothing documented on the reverse of the chart to indicate whether the medicines had been omitted for any reason. There was nothing documented to indicate whether staff had identified the missing signature or whether they had attempted to ascertain if the person had received their medicines or not. We asked a member of staff to count the remaining tablets which confirmed the person had received their medicine. However, it was unclear why staff had not carried out these checks themselves. In addition, the medicine prescribed was specific to a person's medical condition and a missed dose could cause adverse effects on the person's wellbeing. This error was identified in a weekly medicines audit undertaken on 28/02/2017.

We noted within the record of medicines which required additional security a signature was not recorded. This related to a dose of medicine that had been administered on 31/01/2017, but there was no signature recorded in the "Given by" column. Other entries had been completed in full. A subsequent investigation of this gap in recording established it had been a recording error.

MARs included information on why medicines were needed. There was information about people's allergies and photos of the person on the MARs to ensure correct identification of the person when administering. Medicines were supplied by a pharmacy on a monthly basis; a record was kept of all medicines received at the home. All medicines were stored securely, including those which required additional security.

Items that required refrigeration were stored in fridges. The temperatures of these were monitored daily as well as the temperatures of both clinical rooms.

Some people had been prescribed medicines on a PRN (as required) basis. When this was the case, there were PRN protocols in place to inform staff of the dose that could be administered as well as the reasons why people might require additional medicines. When PRN medicines had been administered, the reasons why had been documented on the reverse of the MAR. This meant that staff were able to identify trends or issues and inform the person's GP if they had concerns about the taking of these medicines.

Although people's care plans sometimes described the way people preferred to take their medicines, this was not consistently seen. The plans on the Willows unit were detailed but this was not seen consistently on The Parsonage unit. In addition, this detail about people's preferences was not held within the MARs charts, which would assist with ensuring person centred medicines administration, took place.

We observed parts of two medicine rounds. During both of these, the staff members took their time with people. They ensured people had a drink, checked they had taken all medicines before signing the MAR chart and asked people if they required additional medicines such as pain relief.
People had their medicines regularly reviewed. Records showed the service had a good relationship with the local pharmacy and with the local surgery. One member of staff responsible for administering medicines on the Willows said, "I know if I have any medicine queries, I can call the pharmacist for advice, they're very helpful".

The provider was not following Department of Health guidance (or similar) in that slings used to support people in a hoist were being used communally rather than each person having and using their own sling. This was confirmed by staff we spoke with and slings were stored together without any consistent indication of which sling was to be used by which person. Staff recognised this was an infection control risk and were able to tell us why each person should be using their own sling. One staff member told us "It is so any skin infections are not given to other people." This meant people were placed at potential risk of cross infection. The day following our inspection the provider advised us all slings had been identified for a specific person, labelled as such and issued instructions all slings to be stored in the person's room.

Staff demonstrated a good knowledge and understanding of how they should be protecting people from risks of infection. However, this was not consistent as noted in relation to the use of slings. Staff explained when to use protective clothing. They told us of one person who had an infectious condition and how they responded to this to prevent other people and staff being placed at risk. People and visitors commented how the home was always clean and free of odours. This was our observation on the two days of the inspection.

Risk assessments had been put in place in response to people's care needs related to falls, nutrition and moving and transferring people. These outlined specific needs of people in relation to the risks such as use of specific equipment when moving or assisting with transfers. In others there was information for staff to ensure people's nutritional needs were monitored through the use of food charts and instructions about frequency of weighing of the person. In some there was guidance about how people were to be supported or have their meals. Staff were aware of people who needed this support and risks if the assistance was not provided. There were personal emergency evacuation plans (PEEP) in place. These identified people's needs so that staff and emergency services could respond as necessary in the event of an emergency. This meant people's safety and welfare in the event of an emergency was protected.

Staff confirmed that as part of their recruitment criminal record checks and references were obtained including references from previous employers. Records confirmed these and other checks were undertaken. This meant people could be assured employees were fit to work with vulnerable adults.

People told us there were staff available to provide help and assistance when it was needed. One person said, "I feel safe with them (staff) around all the time. When you are in your room there is a buzzer, they always come and answer it." and another person said, "There are always staff around to help me." A third person told us "If I need any help, if I am concerned or worried then the call bell is answered promptly." A care professional commented to us how "Well staffed" the home was.

We observed staff being available to support people. On one occasion a person was calling for help and a staff member responded promptly asking the person what help they needed. Staff were available in the lounge area particularly for when people became upset or anxious because of their dementia.

Staff spoke of there being sufficient staff. One said, "There are always enough staff around" another "Staffing is very good, we have time for people always feel enough staff." The registered manager told us there was regular reviewing of the staffing arrangements. This was through observation, talking with staff and care reviews. They told us how a review of accidents and incidents had resulted in decision for member of staff to be present in the lounge areas during the day. This was observed during our inspection.

Good

Is the service effective?

Our findings

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.

There were people using the service who lacked capacity to make some decisions. One person had regularly refused medicines and lacked capacity and a best interests decision had been made to have medicines administered covertly (in food or drink). Records confirmed professionals and other interested parties such as the person's representative and pharmacist had been part of reaching this decision. People who had capacity and required bed rails had given consent for their use. Where people lacked capacity to give consent for their use best interest decisions had been made. This meant action had been taken in compliance with the MCA to safeguard people's health and welfare and uphold their rights.

People who lack capacity 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). During this inspection the registered manager told us they had made a number of applications under the MCA for DoLS. These applications related to people who were living in the home and needed protection and safeguards because of potential risks to their health and welfare if they left the home independently. To date three authorisations had been made with no conditions. This demonstrated the registered manager had taken action to protect the welfare and uphold the legal rights of some people in the home.

We noted for one person the service had respected a decision made by the person despite it resulting in risks to their health and welfare. The service had involved health professionals in ensuring the person was aware of the choices and options they had and the potential risks because of the decision they had made. This demonstrated where people had capacity the service respected people's right to make decisions which potentially placed them at risk.

We observed care staff supporting people with care tasks and asking for their consent. For example we observed one care staff saying, "Where would you like to sit, here or in the lounge?" and "Can I help you with that?"

All staff received core skills training such as first aid, fire safety, moving and handling and infection control. Staff had also been provided with specific training to meet people's care needs, such as dementia, pressure care, nutrition and hydration. Records confirmed staff had all undertaken this core skills training and had completed updating training in some areas such as moving and handling. This meant staff received the necessary training to undertake their role in a competent and professional manner.

Staff told us how they felt the training provided them with skills and understanding of how to support

people particularly those living with dementia. They told us about specific training which focused on "The essence of care." which is recognised guidance for standards of care. This training provided staff with skills to provide person centred care in relation to people living with dementia. To identify how to interpret and understand non-verbal behaviour as being part of the person's reality. One staff member told us it had given them more confidence in understanding and responding to people. Another staff member told us this training was about "Viewing behaviours as the person telling us what they are feeling." One staff member said, "The management team who lead the training are so passionate about changing the way care is delivered. I have learnt so much." This meant the provided had introduced training which was specific to the needs of people living with dementia in order to improve the quality of care and interaction between people and staff.

Staff received an induction programme linked to the Care Certificate. The Care Certificate standards are set by Skills for Care, a nationally recognised professional care organisation. The certificate aims to ensure staff have the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Staff told us the induction included a period of shadowing experienced staff and looking through records, they said this could be extended if they needed more time to feel confident.

People told us how they enjoyed the meals provided by the home. One told us "There is always a good choice and if I do not like something they make sure I get what I do like." Another person said "The food is lovely no complaints." A relative commented, "My wife can enjoy her lunch whenever and wherever she wants which is fantastic." Another visitor had commented, "I visited my friend and the food was lovely, my friend assured me that it was always like that."

We observed lunch on the two days of our inspection. Staff were available to support and assist people where this was needed. They did so in a sensitive way. They sat beside them, told people what the food was, regularly asked if they were enjoying it and if they wanted more. When one person indicated they wanted a drink, a staff member covered their meal to keep it warm before going to get the drink.

Staff knew people's preferences in relation to their food. Staff were observed checking with people what they wanted to eat and giving visual choices so the person could make a more informed decision. On one occasion a person was taken to the hot trolley and shown the food available.
In one person's care plan it documented how the person needed specific equipment to help them eat their meal. We observed how these instructions had been followed.

Staff were very supportive particularly with one person who was confused and not sure what was happening. They made sure the person remained in the dining area encouraging them to stay and have their meal. There was a calm and relaxing environment during the mealtime. This meant people had the opportunity to have a positive dining experience.

Care plans showed people were regularly assessed for the risks of dehydration, malnutrition and choking. Where necessary external advice and guidance had been sought from the speech and language therapy team (SALT). Care plans contained clear guidance for staff on the type of diets that people required. People's preferences in relation to food and drink had also been documented. People were weighed regularly and if people lost weight appropriate and timely action had been taken. When people were having their food or fluid intake monitored, the associated charts were completed in full.

Some people had diabetes, which was controlled with medicines and diet. Staff knew which people were living with diabetes and were knowledgeable about what types of food people should be eating. For example, one person said they wanted a particular type of dessert and the staff member said "I just need to

check with the nurse what your blood sugar was, and if it is ok for you to have it." This showed that staff were familiar with people's nutritional needs as well as their medical needs.

People had access to a range of community health services including GP's, chiropody and opticians. There was also involvement from professionals including social workers and community psychiatric nurses. There were weekly visits from a nurse practitioner to respond to any health needs which did not require the intervention of a GP. Nurses we spoke with commented on the good relationships they had with health professionals.

Staff had the opportunity to have one to one supervision. This is where they met with a manager or senior member of staff to discuss their work, performance and other matters related to how they were able to meet the needs and responsibilities of their role. Staff confirmed this was usually at six monthly intervals.

Good

Is the service caring?

Our findings

People described care staff as "Kind and caring." One person said, "I am able to wash and dress myself, but the carers treat me very nice, it's like a big family, we all feel like that." Another said, "The carers are so kind and listen to me." A staff member told us "I love the atmosphere and warmth here. When I come to work I see staff hugging people and treating them with compassion and warmth. It just seems to run through the staff veins." A relative had commented to the home, "(NAME) has dementia and is well cared for and treated with respect. Although she is sometimes difficult and confrontational the staff are able to handle this gently and defuse her moods." Another had commented, "My relative has been treated with the utmost respect and care. The staff have a very tactile approach and never pass them by without a kind word and a hug which goes a long way, great approach."

We observed staff supporting people in a respectful and dignified way. They responded to people's anxieties and distress in a calm, thoughtful and sensitive way. In one instance we observed a staff member sitting and calming a person who was distressed in their belief their relative had just died. The staff member re-assured the person and did not challenge the belief which was false and due to the person's dementia. On another occasion a person was continually getting up and wanting to walk around. The staff member tried to distract the person with an activity. This was not successful and the staff member accepted the person just wanted to continue their walking around the home. This demonstrated the staff ability to support people in a caring and sensitive way and accepting of people's behaviour.

People were treated with kindness and compassion. We observed positive interaction between staff and people living in the home. There was a relaxed and warm environment. Where people became upset staff were available to respond in a positive way. For example, we observed how one man became tearful, a member of staff immediately noticed this and went over to offer reassurance. They said, "Don't get upset. Would you like a cup of tea and chat with me?" This resulted in the person calming down and talking to the staff member about why he had been upset. On another occasion a person was not sure where their room was. A staff member went to them and said, "You live just down here. I will walk with you, it is not far."

We observed staff treating people with dignity and respect. For example, ensuring they were on the same eye level as people when they were talking to them and knocking on bedroom doors before entering. Staff described how they ensured people had privacy and how their modesty was protected when providing personal care. For example, closing doors and curtains and explaining what they were doing. Staff had an understanding of confidentiality; we observed they did not discuss people's personal matters in front of others. All records relating to people were stored securely. This meant people were supported by staff who understood the importance of respecting people's privacy and dignity.

People were encouraged to be as independent as possible. One person told us "I think they look after us very well. They try to let us do as much as we can, but there to help when we need it." We observed staff assisting people but in an enabling way giving people time to do things for themselves but aware when it proved too difficult and offering to help. For example when having their meals or moving around the home.

Where able people are involved in their care planning arrangements through talking with care staff or nurses. One person told us "Staff always ask me if I am getting the care I need." and another said, "We (with their relative) met with a nurse about the care I needed." Relatives of some people told us they had had the opportunity to talk about their relatives care needs. One relative told us "We are fully involved."

People and their relatives told us visitors could visit at any time, there were no restrictions and they were made to feel welcome. One relative told us "We are welcome to visit any time." Another visitor had commented, "I was welcomed into the home, it is a very welcoming and warm environment." During our inspection we observed visitors coming to the home throughout the day, there was a visitors signing in book in the reception so the staff knew who was in the building in case of an emergency.

Good

Is the service responsive?

Our findings

Care plans for each person living in the home were detailed and thorough which made sure staff had the information they required to support people in their chosen way. They contained information about, for example, peoples' medical condition, medicines, previous social history, likes and dislikes, mental health, night requirements, mobility and communication needs. Staff were able to demonstrate their knowledge of specific needs of people for example how one person liked to be dressed in a particular way. Another person liked to wear trousers rolled up to bare their skin below the knee and have bare feet. This was accepted by staff as part of their wishes and choice.

Some people had preferences about the gender of care staff who supported them with personal care. Care plans provided this information and staff were able to tell us which people preferred only female or male care workers. One person told us "Staff know I do not like men giving me care and they always make sure I have a woman."

A health care professional told us a strength of the home was "There is a person centred care approach." This was reflected in comments made to us by care staff: "Knowing people as people and individuals" and "People are so much happier living their lives as they want to live their lives." and "We join people in their reality." This reflected an individualised approach and also recognised how people living with dementia have very specific needs as a result of their illness.

Activities reflected the needs of people living with dementia. Whilst there were group activities there was a focus on staff spending individual time with people. We observed care staff helping people do quizzes or colouring. One person was helped to build items using building blocks (this person had been a builder). Another person was supplied with a toolbox again this reflected their previous occupation. Another person had various materials which they used to dress a doll, they had been a seamstress. Another person was encouraged to write poems having been a writer.

Activities were arranged to meet other people's needs and not purely those who were living with dementia. One person told us how staff took them out to the shops and in the summer people helped with the garden. Another person told us how they enjoyed the activities especially bingo. There were regular religious services to meet people's spiritual needs. One person told us "I really like the singing, I am happy when I am singing."

On the Parsonage unit where people living with dementia are cared for we observed how staff were tactile towards one person. Their care plan said how they responded well "To affection". Talking with staff they recognised the importance of personal touch and a tactile approach to supporting people. However, they appreciated this was not an approach suited for some people and a matter of personal preference and choice. One relative had commented to the home how this approach was "Exemplary". Another care plan spoke of how physical touch was important to that individual: "Holding of the hand or giving a hug could be comforting to this person." This meant the service was promoting an environment which recognised the importance of person centred care and reflecting of people emotional needs.

We observed staff responding to people's specific needs around communication. For one person they used a whiteboard to communicate because of their hearing disability. A relative spoke of how staff used "sensory items" to help their relative because they were visually impaired.

People and their relatives contributed to a pre-admission assessment and planning of their care where they were able to. This involved the person or their representative and covered their needs, abilities, interests and other care needs." We saw care plans and assessments which provided this information. One relative told us "We are aware of the care plan but Dad is so involved that it doesn't need much input from us at the moment. He is included in everything."

People and their relatives were aware of their right to make a complaint if they had concerns about the quality of care they were receiving. People told us how they would talk to staff or the registered manager if they had a worry or concern. One person said, "I have never had to make a complaint but would if I needed to. I am sure they would listen and do something about it." Another person told us "I have never had to complain but the staff are very approachable and will always listen carefully to any concerns I have. You can talk to any of the staff and they will always listen." A relative told us "I have not had cause to raise a concern but would be happy to do so if I saw something I was unhappy with." Another relative said, "I do see the manager around and would be happy to raise issues with her if I needed to-she is very approachable. A third said, "If issues have been raised they have been dealt with quickly and adequately." There had been one complaint which had been investigated and responded to in a positive way. This meant there was an environment where people and their relatives felt able to voice any concerns.

Requires Improvement

Is the service well-led?

Our findings

There were comprehensive systems in place for the quality monitoring of the service. However, they had failed to identify areas for improvement such as: arrangements for safe administering of covert medicines, safe use of slings and responding and reporting of incidents. This demonstrated these systems failed to be effective and robust.

The above were a breach of Regulation 17 of the Health and Social care Act 2008

There were reviews and audits of accidents and incidents. These had led to actions to alleviate risks to people's health and welfare. For example: referral to the mental health team for their involvement in supporting people, review of staffing deployment resulted in ensuring staff member always available in the lounge areas (which we observed) and use of equipment to monitor people's movement to ensure they remained safe and staff responded to any risks to the person or others. This meant the service learnt from accidents and incidents to improve the safety and wellbeing of people living in the home.

Staff spoke of a culture which promoted a service which as one staff member told us "Feels like a community". There was a sense of the home being a home where people particularly those living with dementia were recognised as individuals and all that entailed in terms of respecting their rights, behaviour, choices and wishes. Staff spoke of "Engaging with people" and "Working alongside people." One staff member told us "People are so much happier, living their lives, things are not a problem as long as they are safe." This meant there was a culture where people were respected for their individuality and particularly for those people living with dementia recognition of their specific needs.

Staff described the manager and senior staff as "Approachable" and "Supportive and caring" and how they promoted an environment where there was a sense of teamwork and commitment. One staff member commented, "All staff want to work here, there is more of a commitment."

Staff spoke of an open and valuing culture: "We are all happy to ask questions and challenge things, which we couldn't do before." and "We have a good team here, and we have all chosen to improve this place and make it better." Another staff member told us "The atmosphere here is good; the staff all feel supported and are valued."

The registered manager reiterated and echoed some of the comments made by staff. They spoke of a service where people "Live well and die well". Where staff "Take ownership of the service" respected and understood Frome Care Village was people's home and the role of staff in promoting caring care.

The registered manager maintained their professional knowledge through networking with dementia services, attending relevant conferences and through contact with other registered managers of care providers. They had also presented their "Houses" model of care to local providers at a conference. They had attended local study groups at the health centre looking at community mental health, caring for people living with dementia and tissue viability. This helped to ensure people were cared for in line with up to date

practice guidance,

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 17 HSCA RA Regulations 2014 Good governance The system for the monitoring of the quality of care and arrangements to support the providing of care did not always identify areas for improvement. This meant these arrangements failed to be robust and effective.