Ifield Park Care Home Limited

Ifield Park Care Home

Inspection report

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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

The inspection took place over two days, 21 and 24 November 2017 and was unannounced. Ifield Park Care Home provides accommodation for up to 94 people who need nursing or personal care. The home comprised four units, two providing nursing care, one providing residential care and one providing care for people who were living with dementia. The home is situated in a residential area on the outskirts of Crawley. Short stay or respite care is available in each unit. The provider is a charitable organisation.

The registered manager was in attendance on both days of the inspection. 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. At the last inspection on 5 May 2015, the home was rated Good overall. At this inspection we identified two breaches of the regulations and other areas of practice that needed to improve.

Staff were not consistently following the provider's medicine policy and this meant people were at risk of not receiving their medicines safely. A medicine administration error had not been identified. Some people were receiving PRN (as required) medicines but clear guidance for staff was not consistently provided in all areas of the home. Storage of medicines was not consistently monitored.

Some management systems were not always effective in identifying shortfalls and omissions in the quality of the service. Some records were not complete. This had led to inconsistency in some areas of practice across the home.

One area of the home specialised in providing care and support for people who were living with dementia. This part of the home had been recently refurbished and provided a clean and bright environment. We made a recommendation that the provider seeks further information about best practice in the use of colour and design within the environment to help people with dementia to orientate themselves in time and place. Staff had received training in dementia but our observations were that people were not consistently supported with meaningful occupations that were stimulating for them. We made a recommendation that the provider finds out more about providing meaningful occupation, based upon current best practice in relation to the specialist needs of people living with dementia.

Whilst there were enough staff on duty to care for people safely, the deployment of staff in some areas of the home meant that people waited longer then they should expect for their needs to be met. People in some areas of the home said it took "too long" for their call bells to be answered. Our observations were that at some times of the day staff were not always available to support people. This was identified as an area of practice that needed to improve.

Staff had received training in the Mental Capacity Act 2005 (MCA) and demonstrated an understanding of the principles of the legislation. However records did not always contain mental capacity assessments that

detailed how specific decisions had been made in people's best interests. This was identified as an area of practice that needed to improve.

People told us they enjoyed the food provided at the home. Their comments included, "The food is lovely," and "The food is really nice." Risks associated with people's nutritional and hydration needs were identified. However our observations were that some people did not always receive the help they needed to eat their food. This was identified as an area of practice that needed to improve.

People told us they felt safe living at the home, one person said, "Yes I feel safe, they look after things for me." Risks to people were identified, assessed and care plans guided staff in how to manage specific risks. Environmental risks were assessed and monitored and the home and equipment were maintained in good order and kept clean. The registered manager monitored incidents and accidents to ensure that lessons were learned and to drive improvements. Staff demonstrated a clear understanding of their responsibilities with regard to safeguarding people and knew what actions to take if they were concerned about people's welfare. One staff member said, "I would speak up because we are here to protect the residents."

Staff told us they were well supported in their roles and they received the training and supervision that they needed. People told us they had confidence in the skills of the staff. One person said, "The staff are well trained, sometimes they have to deal with difficult situations and they cope very well."

Peoples' care plans were based upon assessments of their needs and wishes. People and their relatives said they had been involved in developing care plans and that their views and opinions were considered. Staff supported people to access health care services and we saw that a range of health care professionals had contact with people at the home. One visiting health care professional told us that staff always made appropriate requests and complied with any guidance provided about people's health conditions.

People and their relatives spoke highly of the caring nature of the staff. One person told us, "The staff are all nice people," another person said, "The staff here are very caring." A visiting relative said, "My relative enjoys a good relationship with the staff." Staff were knowledgeable about the people they were caring for and described what was important to them. One person told us, "They have got to know me well, they are very kind." People were supported to express their views and staff were using a range of methods and tools to support people who had communication difficulties to indicate their preferences. Staff demonstrated a good understanding of the importance of maintaining people's dignity, privacy and confidentiality. People were supported to remain as independent as possible. One person told us about how they were supported to manage their own medicines.

Staff were providing care in a person centred way. One staff member said, "We get to know people very well." A relative told us they had confidence that staff would notice any changes, they said, "I think they are on the ball in that way, they look for changes all the time." There was a wide range of organised activities arranged by dedicated activities co-ordinators. People told us they enjoyed the activities on offer; one person said, "The staff are really enthusiastic and always encourage people to join in."

There was a complaints system in place and the registered manager had ensured that any complaints were responded to in a timely way. One relative told us about an issue they had raised, saying, "I think they understood and will respond."

People were supported to make plans for care at the end of their life. This included recording their wishes about where they would prefer to die and any particular spiritual or cultural needs. Staff spoke compassionately about how they cared for people in the last days of their life and described the importance

of supporting relatives. One staff member said, "We can make a difference with the right planning, making the room as comfortable as possible, having music playing quietly to create a calm atmosphere and above all making sure people's symptoms are controlled."

People, their relatives and staff members spoke positively about the management of the home. Comments included, "It's very well run," and "They do a very good job." One staff member described the registered manager, saying, "They are very caring, like everyone's mum." There was a clear management structure and staff understood their roles and responsibilities. Health care professionals spoke well of working in partnership with staff at the home. Staff had developed positive links within the local community including with a hospice, nursery school and local college.

At this inspection we found the provider in breach of legal requirements with regard to safe care and treatment and good governance. 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.

Staff were not consistent in following safe practice in line with the provider's policy for administering medicines.

There were enough staff to care for people safely but the deployment of staff in some parts of the home meant that people did not receive care in a timely way.

Risks to people were assessed and managed and staff had a good understanding of their responsibilities to safeguard people. There were robust infection control procedures.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's capacity and consent were not always clearly assessed and documented.

People spoke highly of the food. Some people did not receive the help they needed at mealtime.

Staff received the training and support they needed.

People received support to access health care services.

Is the service caring?

Good

Staff were kind and caring.

Staff were caring and supported people to be involved in decisions about their care.

Staff respected people's dignity and maintained their confidentiality.

People were supported to retain their independence.

Is the service responsive?

Good

The service was responsive .

Staff cared for people in a personalised way and supported them to maintain relationships that were important to them.

Staff supported people to plan for care at the end of their life.

People felt confident that their concerns or complaints would be listened to and acted upon.

There was a range of organised activities available at the home.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Some management systems and processes were not effective in identifying shortfalls and omissions in the quality of the service.

Firm links with the local community and services had resulted in benefits for people and staff. There was a clear vision for developing the service.

There was a clear leadership structure with identified management roles. Staff understood their roles and responsibilities. The registered manager had submitted notifications to CQC in a timely way.

Ifield Park Care Home

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 21 and 24 November 2017 and was unannounced. One the first day of the inspection the inspection team consisted of three inspectors and two experts by experience. An expert by experience is someone who has personal experience of using, or caring for someone who uses, this type of care service.

Before the inspection we received feedback from a health care professional who had involvement with people who lived at the home and had provided some staff training sessions. We reviewed information we held about the service including any notifications, (a notification is information about important events which the service is required to send to us by law) and any complaints that we had received. The provider had submitted a Provider Information Return (PIR) before the inspection. A PIR asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. This enabled us to ensure that we were addressing any potential areas of concern at the inspection.

We spoke to 21 people who use the service and four relatives. We interviewed 17 members of staff and spoke with the registered manager. We spoke with a visiting health care professional and spent time with people and making observations around the home. We looked at a range of documents including policies and procedures, care records for 18 people and other documents such as safeguarding, incident and accident records, medication records and quality assurance information. We reviewed staff information including recruitment, supervision and training information, team meeting minutes and the provider's information systems.

At the last inspection on 5 May 2015, the home was rated Good overall.

Requires Improvement

Is the service safe?

Our findings

People we spoke with in each area of the home, told us that they felt safe living at Ifield Park Care Home. One person said, "Yes, I feel safe, they look after things for me. There's always lots of people about." Another person said, "They help me with showering because I'm a bit unsteady, they're always looking out for you." A third person said, "If you need help there's always staff around, I feel very safe here." Despite these positive comments we found some areas of practice that required improvement.

People were receiving support to have their prescribed medicines. Staff were trained to administer medicines safely but practice in this area was inconsistent. We looked at how medicines were administered in each area of the home and found that not all staff were following the provider's medication policy and procedure. For example, the dose of one person's medicines had been changed following a blood test, but staff had continued to administer the previous dose. We brought this error to the attention of a staff member and the registered manager. Immediate action was taken to contact the GP in line with the provider's policy for managing medicine errors. A staff member said that the GP was satisfied that no harm had come to the person and they took action to ensure the mistake was rectified.

Some people were prescribed PRN (as required) medicines. Good practice guidance for care homes produced by the National Institute for Clinical Excellence (NICE) states that PRN medicines, that may include variable doses, should have clear guidance for staff regarding when and how to use such medicine, what the expected effect will be and the maximum dose and duration of use. Although in some areas of the home clear PRN protocols has been completed, this was not consistent for all people who were prescribed PRN medicines. This meant that some people were at risk of not being given PRN medicines consistently and in accordance with prescribed instructions. For example, one person had been prescribed PRN medicine for pain relief, however there was no guidance on the combination that could be given or how often, this could have resulted in an overdose and harm to the individual.

Medicines were stored securely in a number of designated clinical rooms. Some medicines needed to be kept refrigerated. Guidance from the Royal Pharmaceutical Society of Great Britain (RPSGB) states that 'Medicines need to be stored so that the products are not damaged by heat or dampness,' this is because changes in temperature can affect the efficacy of the medicine. The provider's medication policy and procedure stated that where medicine needed to be refrigerated the temperature of the refrigerator must be recorded twice daily to monitor that medicines were kept within the correct temperature range. However temperature records were not being consistently maintained in line with this policy. This meant that the registered manager could not be assured that all medicines were stored within safe temperature limits at all times.

Staff were not consistently following the provider's policy and procedures for managing medicines safely and this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives had mixed views about whether there were enough staff to care for people. Some

people who were living in the residential part of the home said they felt there were enough staff. One person said, "I've always thought there were enough staff. I have used the call bell sometimes and a member of staff came straight away." Another person told us, "There are enough staff and they put themselves out. I've used the call bell at night and they have been very quick to come." Staff in the residential area of the home also spoke positively about staffing levels. One staff member said, "If we are short of staff the senior staff and the manager will help out. We have agency staff too and they are mostly the same ones who come. Another staff member said, "At busy times we still have enough staff on duty. The managers work with us if necessary. We do have time to chat to people and spend time with them."

In other areas of the home people were less positive about staffing levels. One person told us, "They (staff) are always so busy, they need more help." A relative said, "I visit at odd hours, I would say that they are often short staffed, particularly in the evening." Some people in some areas of the home said it took "too long" for their call bells to be answered. We asked the registered manager how they monitored staff response to call bells. They told us that the call bell system could produce reports however these were not available for all areas of the home. The registered manager said they relied upon feedback from people and their own observations when walking around the home to determine if call bells were answered within a reasonable time. People told us that they had to wait a long time for their bell to be answered. One person's view was that staff were too busy and that was why it took a long time for them to respond. We observed that some people did not have a call bell within their reach. Staff told us this was because not everyone was able to use a call bell, however this information was not included in all care plans and a risk assessment had not been completed.

Some staff told us that there were not always enough staff. One staff member said, "We are sometimes short and that means that people have to wait, so some have to get up later than usual." However, another staff member said there were enough staff because the provider used agency staff when needed. They told us, "If we are short of staff or if we need additional staff they use regular agency." The provider did not use a formal tool to assess how many staff they needed to care for people. The registered manager said that staffing levels were determined depending upon the needs of people. This was discussed and agreed between the managers to ensure adequate staffing levels. We noted that rotas showed consistent staffing levels had been maintained. The registered manager said, "I rely on the staff's knowledge and expertise, if they feel they need more staff we can flex up to accommodate."

Our observations on both days of the inspection showed that staffing levels were safe but deployment of staff meant that people were sometimes waiting longer then they should expect to have their needs met. In the nursing unit of the home there appeared to be suitable numbers of staff most of the time but during some periods of the day people were left without the support they needed. For example, when staff took a break, people were left with no support in the lounge area and people did not have access to a call bell to seek attention if they needed it. One person was observed to be distressed and there were no staff in the vicinity for more than ten minutes to offer support. Eventually a staff member came and reassured the person. In another area of the home, where people were living with dementia, some people were not receiving the help they needed at meal time. During the lunchtime meal staff members was seen to be very busy and did not notice when one person was having difficulty with eating. One staff member was heard offering verbal encouragement to the person as they passed by but it was not until the end of the meal when other people had finished, that another staff member came and sat with the person and gave them the assistance they needed.

Whilst there were enough staff on duty to care for people safely, the deployment of staff in some areas of the home is an area of practice that needs to improve.

Staff were consistently recruited through an effective recruitment process that ensured they were safe to work with people. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff had obtained proof of identity, employment references and employment histories. We saw evidence that staff had been interviewed following the submission of a completed application form. Files contained evidence to show, where necessary, staff belonged to the relevant professional body. Documentation confirmed that nurses employed had up to date registration with the Nursing and Midwifery Council (NMC).

Staff demonstrated a firm understanding of their responsibilities with regard to safeguarding people. They were able to describe how they would recognise signs of abuse and knew what to do if they had any concerns. One staff member told us they had received safeguarding training as part of their induction. Another staff member gave clear examples of how they would raise any concerns both inside and outside the organisation. A third staff member described what actions they would take if they noticed unexplained bruising, saying, "I would report it straight away to the nurse on duty or report it to the manager." Staff were able to tell us about the provider's whistleblowing policy. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. One staff member said, "I would speak up because we are here to protect the residents."

Risks to people were assessed and care plans provided guidance for staff in how to minimise risks. For example, one person was assessed as being at risk of falls. The care plan provided a clear history and description of the person's current level of mobility, as well as their stated aim of returning to their former level of mobility. The care plan identified the person's wish to remain as independent as possible and guided staff in how to support the person with use of a walking frame but also to offer wheelchair assistance when required. We observed that staff were encouraging the person to use their walking frame.

Another person, who was living with dementia, was assessed as being at high risk of falls and a manual movement assessment was in place to guide staff in how to support the person with the use of a stand-aid. We observed staff undertaking this task in line with the care plan. The staff members talked to the person throughout the process, reassuring them and giving clear instructions. They checked that the person was comfortable before commencing and assisted the person to move in a safe and dignified way. During the inspection we observed two further examples of staff supporting people to move with the use of hoisting equipment. Each time staff were observed to be reassuring and caring in their approach whilst completing the manoeuvre with confidence and skill.

Some people had been assessed as being at risk of developing pressure sores. Validated tools, called Waterlow assessments, were being used to identify the level of risk for each person and this was reviewed on a monthly basis. A skin condition care plan guided staff in how to ensure risks to skin integrity were minimised, for example assisting the person to reposition every two hours. Records confirmed that staff were providing care as described. A body map was used to identify areas of pressure damage and guide staff in where to apply topical creams to prevent further damage. Care records showed that where a person had pressure wounds these were being assessed on a regular basis. Some people had been prescribed an air pressure mattress to prevent further skin breakdown. One skin condition care plan stated, 'The mattress must be checked daily to ensure it is working. ' Staff told us that the mattress was regularly checked, however, this was not being recorded. This meant that the registered manager could not be assured that all risks of pressure area damage were being effectively managed. We brought this to the attention of the person in charge of the nursing unit who took immediate action to rectify this omission. On the second day of the inspection the recording charts had been amended to include checks on all pressure mattresses.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular checks on equipment and the fire detection system were undertaken to ensure they remained safe. Hot water outlets were regularly checked to ensure temperatures remained within safe limits. Gas, electrical, Legionella and fire safety certificates were in place and renewed as required to ensure the premises remained safe. People's ability to evacuate the building in the event of a fire had been considered and each person had an individual personal evacuation plan. We noted that a stair gate was inadvertently left open during the inspection which meant that people were at risk of falling on the stairs. We brought this to the attention of the registered manager who explained that people did not usually have access to that part of the building. However the registered manager took immediate steps to rectify the issue. On the second day of the inspection the stair gate had been replaced with a key pad lock on an adjacent door to reduce the risk of people accessing the stairway and falling.

Incidents and accidents were recorded and monitored. The registered manager received reports from each area of the home and maintained oversight of all incidents and accidents. They described using this information to learn and make improvements in the home. For example, when a medication discrepancy was reported an investigation was undertaken to determine the reason for the error. This had resulted in additional training for staff in how to dispose of medicines appropriately.

People and their relatives told us they were satisfied with the level of cleanliness around the home. One person said, "My room is hoovered every day." A relative said, "The place is always very clean and tidy and it always smells fresh everywhere." Staff told us that they had the equipment they needed to prevent infection and we observed them using appropriate personal protective equipment including gloves and aprons when needed. Staff had received training in how to protect people from risks of infection and there were robust systems in place including colour coding for laundry bags to reduce risks of cross contamination. We observed that handwashing facilities and hand sanitisers were available throughout the home and staff were seen to be following good infection control procedures. Equipment, such as walking frames, were seen to be clean and in good order.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us that they had confidence in the staff and felt that they had the skills they needed to look after people effectively. One person said, "The staff are well trained, sometimes they have to deal with difficult situations and they cope very well." Another person said, "They know what they are doing, they are very efficient." A relative said, "I think they get good training, they seem to know what they are doing." In the area of the home specialising in supporting people who were living with dementia one person told us, "The staff are quite well trained, they help me with showering and keep up well fed." A relative told us they felt staff were competent in caring for their relation. They explained, "They need to hoist my (relative) and they are very good, very professional." However, despite these positive comments, we found some areas of practice that needed to improve.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were being met.

Staff had received training in the MCA and everyone we spoke with was able to demonstrate a basic understanding of the principles of the Act. One staff member said, "We must assume people have capacity and respect their wishes. If they don't have capacity this has to be assessed and decisions are made on their behalf, usually with the family." Some staff had good knowledge of MCA and could describe how it related to their work. One staff member explained why a person was subject to DoLS and what this meant for them. Another staff member described how someone was receiving their medicines covertly (without their knowledge). They explained the process of determining whether the person had capacity to refuse their medicine and the best interest decision making process that followed. Throughout the inspection we observed staff were checking with people before providing care to ensure that they had people's consent. For example, we heard staff members saying, "Can I give you a hand with that?" "Would you like me to help you?" and "Is it alright if I put this on now?"

Care records showed that mental capacity assessments were not always completed in line with legal requirements. For example, observations of support identified that people had bed rails in place. Within the MCA, where people's movement is restricted, this could be seen as restraint. Bed rails were implemented for people's safety but do restrict movement. Bed rails risk assessments were in place which considered the risk and how to meet it. However an assessment of capacity had not always been undertaken to ascertain if the person could consent to the restriction of their freedom, for example in the use of bed rails. This meant that it was not explained why the bed rails were implemented in their best interest and if other options were explored. We discussed with the registered manager how the care plans did advise that people lacked

capacity but we identified that this needed to be underpinned with a mental capacity assessment and best interest decision to demonstrate why a specific decision is in the person's best interest, in this case for a bed rail to be used. This is an area of practice that needs to improve.

Most people told us there was plenty to eat and drink and they enjoyed the food and drink available at the home. Their comments included, "The food is good, I usually enjoy my meals," and "The food is lovely," and "The food is really nice." People's dietary needs had been assessed and care plans included guidance for staff in the support they needed. One person told us, "I'm diabetic and there haven't been any problems with that at all." People's records included eating and drinking care plans which addressed specific dietary needs and recorded their preferences. For example, one person had a diabetic support plan providing clear guidance for staff in how to support the person to manage their diabetes. Another person had been recently assessed by a Speech and Language Therapist (SALT) as needing a pureed diet and thickened fluids. Their care plan had been updated to reflect the SALT advice and a staff member told us that the chef and kitchen staff were aware of all people who had specific dietary needs. People's ability to cut up their food, to make menu choices and any risks with swallowing food were noted. Where people needed specific cutlery or required support to eat their food this was clearly detailed. People's preferences were also included in their care plans and a 'Remember I'm Me' chart provided a useful quick reference for staff. For example one stated, 'Likes lots of tea', another stated 'Dislikes spicy food. ' People told us they could have snacks and drinks when they wanted them. For example, one relative said that staff always saved a supper for their relation if they were out when the evening meal was served. They said "Sometimes he gets up in the night and the staff will make him something to eat and drink if he wants it."

Throughout the inspection we noted that people had drinks near them and staff regularly offered hot and cold drinks to people. We observed the main meal at lunchtime. People who were living in the residential part of the home were mainly seated in the dining area but some people were having their meals in their bedrooms. Staff told us that this was people's choice. Staff brought the meals to people and reminded people what they had chosen. People were offered drinks and some people were being supported with their food. Staff were engaging in conversation with people and the atmosphere was calm and relaxed. People told us they enjoyed the food. In other areas of the home staff were supporting people in a similar way however not everyone was receiving the help they needed. One person, who was living with dementia was having difficulty with their meal. After fifteen minutes a staff member came to support them but the person had fallen asleep and the food was no longer hot. The staff member did not offer to reheat the food. They helped the person with two spoonfuls of food and then left them to carry on alone. Again the person was not able to manage and when the staff member returned, five minutes later, they took the food away commenting that they had eaten enough. A dessert was then placed in front of the person and they were again left to eat but could not manage to get the food to their mouth. Ten minutes later another member of staff sat down with the person and supported them to finish the food. The eating and drinking care plan for this person stated that they 'may require help at meal times as her hands can be unsteady.' A recent review had noted that the person was not eating well and stated 'Now has help at meal times',however the care plan had not been updated to reflect this. The person's weight was being monitored and whilst we did not judge that they were at risk of malnutrition it was clear that they did not receive the help they needed at the lunchtime meal. Our observations were that most people were receiving the help they needed at meal time, however this was not consistent in all areas of the home. Whist we have not judged this to be a breach of regulations we have identified that this is an area of practice that needs to improve.

Some relatives expressed concerns about whether staff had received sufficient training in dementia. One relative told us, "I think the staff are well trained to a point, but they miss little things that make a big difference." Another relative said, "I know they have dementia training but I don't think they all understand. They don't always recognise when something is important to the person. I had to speak to one staff member

about it and I felt shocked that they hadn't understood." We asked staff how they would recognise what was important to people who were living with dementia. One staff member spoke about a person's routine and the order they preferred to do things. Another staff member told us about certain familiar objects that were important to one person. Our observations were that some staff lacked the knowledge and skills they needed to ensure that people who were living with dementia had meaning and purpose within their daily routine. We saw that people were encouraged to join in with a group activity during the afternoon but there was little opportunity for stimulation or meaningful occupation at other times. Staff did not demonstrate a clear understanding of the importance of providing meaningful occupation or stimulation for people who were living with dementia. A relative told us, "I think they (staff) could do more to engage people with a bit more activity." Whilst organised activities were appropriate for people they did not have additional opportunities to spend their day in a meaningful way. For example, people were not included in day to day tasks around the home that could have provided purpose and meaning in their day. There was a lack of available items for people to use independently or with staff support. For example books, magazines, puzzles, reminiscence items to generate conversations, or sensory items to stimulate, soothe or provide interest for people.

We recommend that the provider finds out more about providing meaningful occupation, based upon current best practice in relation to the specialist needs of people living with dementia.

In the area of the home specialised in caring for people who were living with dementia, the environment had been recently refurbished. It was clean and bright and a staff member told us that the design of the building included a circular corridor so that people who liked to walk around independently would not get lost because the corridor would always bring them back to where they had started. Some people had individualised designs on their bedroom doors to help them to recognise their room. There were some brightly coloured chairs situated in parts of the building. Apart from this, the use of colour and design was limited. We noted that the lack of colour around the building made it difficult to identify specific areas which could be disorientating for people who were living with dementia. The registered manager told us that they had not sought advice or guidance about how the environment could help to meet the needs of people living with dementia prior to the refurbishment.

We recommend that the provider seeks further information about best practice with regard to how colour and design in the home can be used to help people who are living with dementia to orientate themselves.

There were effective systems in place to monitor training and ensure that staff were receiving regular updates. Staff told they could ask for training in any subject that was relevant for their role. Records showed that staff were up to date with their training and were booked to attend refresher training when they needed an update. We noted that planned training sessions were taking place on the first day of the inspection and were well attended. Nursing staff had access to external training to ensure their clinical skills were updated. The provider had made links with a local college to enable staff to access short courses and diplomas in care and catering.

Staff told us they felt well supported. They described receiving regular supervision and spoke about a supportive atmosphere. Supervision is a mechanism for supporting and managing workers. It can be formal or informal but usually involves a meeting where training and support needs are identified. It can also be an opportunity to raise any concerns and discuss practice issues. Staff told us that they found supervision to be helpful and supportive. One staff member said, "I have supervision with the senior but the manager and shift leader are always available to talk to at any time. They always say thank you for what you have done, which goes a long way." Another staff member said, "Supervision is helpful because it's regular." A third staff member said, "We discuss training and anything that's worrying me. I have been very well supported and

they let me work flexible hours which has really helped."

One staff member described how they had been supported during their induction when they started working at the home. They explained, "It was very thorough and I had a lot of training to start with. Then there was an introduction to people living at the home and I shadowed experienced staff until I felt confident." Staff told us that new staff members who had no previous experience of working in the care industry received a full induction with a longer period of shadowing to ensure they had the skills and confidence they needed.

People's needs had been holistically assessed and care plans were based upon assessments of their needs and wishes. People and their relatives told us that they had been involved in developing their care plans. Records showed that care plans were regularly reviewed and updated to reflect care delivery. Care planning was person centred and took account of people's diverse needs, including their religion, ethnicity, disabilities and aspects of their life that were important to them. For example, one person's care record included reference to their faith and gave details of how this was relevant to their dietary needs. Another care plan identified a person's sensory needs and included guidance for staff in ensuring their glasses were clean and they were using their hearing aid. A staff member explained why this was important for this person saying, "They need to see and hear what we are saying and doing, so they know what's going on." Another person's care plan included information about their background and noted that English was not their first language. Staff told us that people could access advocates if they wanted to and we saw information displayed on noticeboards around the home regarding an advocacy service.

People's care plans noted their strengths and abilities as well as describing the support people needed and guidance for staff. Although not always explicit, most care plans had identified goals for example, enabling and supporting communication, ensuring that the person remained pain free and maintaining independence in a specific area. This meant that staff had clear guidance on how to support the person to achieve success and regular reviews considered the effectiveness of the care provided.

People were supported to have access to the health care services that they needed. One person told us, "If I need to see the doctor the staff arrange it all, I don't have to worry." A relative said that staff were effective in supporting their relation with their health care needs; they said, "The staff are rigorous about checking blood sugars for diabetes." Records confirmed that people were supported to attend health care appointments and appropriate referrals were made when needed.
People's health was regularly monitored and records showed that staff were proactive in identifying changes and passing information to health care professionals including district nurses and GPs. Routine health care appointments were arranged with professionals such as opticians, chiropodists and dentists. Staff reported having good relationships with local services such as pharmacies, GPs and therapists including a physiotherapist. A visiting health care professional told us that they had a positive relationship with the staff at the home. They said that staff always made appropriate requests and complied with any guidance provided about people's health conditions.

Good

Is the service caring?

Our findings

People told us that they were happy with the care and support they received. Their comments included, "The staff are all nice people," and "They are very friendly girls," and "The staff here are very caring." One person told us, "The staff do pretty well, they are always in and out of my room, I can't fault them." A relative said, "Most of the staff are good, they have people's best interests at heart." Another relative told us, "My relative enjoys a good relationship with the staff." The interactions we observed were kind and caring. Staff were gentle in their approach and patient when supporting people. Staff bent down to make eye contact when talking with people and used gentle touch when communicating or guiding them, for example when helping people to move around. One person confirmed that staff were supportive and kind, saying, "When it was my wedding anniversary they were so kind and caring. I really appreciated the way they spent time with me and were so understanding."

People told us they felt staff knew them well. One person said, "I think the staff have got to know me well." Another person said, "They know me and how I like things, for example they always make sure I have my beads on, they know I like to look nice." People's differences were acknowledged and respected. People were able to maintain their identity, they wore clothes of their choice and their rooms contained their personal belongings and items that were important to them.

Staff spoke about the people they were supporting respectfully and demonstrated that they knew them well. Staff knew about people's personal histories, things that were important to them and their personal preferences. For example, one staff member spoke about the particular routine that was important to one person. Another staff member described a specific family situation and how this was affecting one person. A third staff member explained how they recognised when one person was anxious or upset and how they would support them. The person later told us, "They (staff) knew I was very anxious about my (family member) and when they rang they brought the phone to me straight away to reassure me." The person described a positive relationship with staff members saying, "They have got to know me well, they are very kind."

A key worker system was in place, which enabled people to have a named member of the care staff to take a lead and special interest in the care and support of the person. One staff member described their keyworker responsibilities saying, "We talk to the person about their care plan and make them aware of reviews. We help to keep their room tidy and arrange their things as they like them and keep their family up to date."

People and their relatives told us that they had been included in the care planning process and felt supported to make decisions about their care and support. One person said, "I was very involved with my care plan. They went into great detail and I signed it to say that I agreed with what was written." Another person said, "They did ask a lot of questions of me and my son, they showed a lot of interest in what I wanted." One relative told us, "We were involved in setting up the care plan initially." Other relatives we spoke with confirmed that they had also been involved in development of care plans with their relations.

Staff ensured that people were supported to have choice and control over decisions about their care. Staff

were using tools to assist people to remain in control where possible. For example, some people had communication difficulties which meant that they could not always express themselves verbally. Their care plans included the use of pictorial pain score cards. This enabled the person to indicate to staff what level of pain they were suffering so that appropriate pain relief could be administered. People told us they could choose what time they wanted to go to bed, one person said, "Bedtime is just right for me." Some people had expressed a preference for a staff member of a specific gender to assist them with personal care tasks. This was noted in their care plan and staff said people's preferences were accommodated whenever possible.

People were supported to remain independent. For example, some people were being supported to manage their own medicines. There were systems in place for staff to check that people continued to take their medicines safely and this enabled people to manage some or all of their medicines independently. One person told us, "I see to my own medication, I was given the choice when I came here. Staff check and make sure I don't run out and that I'm still happy to do it myself."

Staff spoke about the importance of maintaining people's dignity and described how they would ensure their privacy, for example, when providing personal care. One staff member said, "I always imagine how I would feel and try and put people at ease, chatting helps and I make sure everything is to hand so people don't feel too exposed." We noted that staff were knocking on people's doors before entering their rooms and signs were placed upon people's doors to remind staff to respect their privacy. One person told us, "They are careful with me, they let me do what I can and then help where it's needed. I never feel uncomfortable, I think because they are so professional." People's confidential information was kept securely and staff were mindful of protecting people's privacy. One staff member said, "We never talk about people in front of the other residents, we are careful about where we discuss things."

Good

Is the service responsive?

Our findings

People and their relatives told us that they felt staff were responsive to their needs. One person told us they liked living at the home because the range of activities was good. They said, "I am much happier now, I feel better since I moved here and I am not so thin and weak as I was. They look after me well and I am never lonely."

Throughout the inspection we observed staff were providing care in a person centred way. One staff member said, "We get to know people very well because over the week we are allocated to work with everyone so we know their preferred ways." Our observations were that most staff were knowledgeable about the people they were caring for. One person, who was living with dementia, found it difficult to orientate themselves in time during the day. We observed that staff were patient and understanding in their approach, using gentle explanations and encouragement. One staff member told us, "We work with the person's perception not challenging them. If they get up in the night for example, we just go with it." Another staff member also described supporting this person saying, "We fit in with what they see as right, work to their timings."

Care plans were well personalised with details about people's particular preferences, dislikes and what was important to them. For example, one person's care plan included details about the type of toiletries they preferred. Another described the person's preference for a bath not a shower and indicated that they liked to get up early in the morning. Care plans included an overview called the 'Remember I'm Me' chart. This provided useful at- a-glance information about things that were important to the person such as certain foods they liked, whether they needed to wear a hearing aid or glasses. Staff told us that this was useful when staff were new or unfamiliar with the person because they were able to get useful and important information quickly without having to read through more detailed care plans.

People and relatives told us that staff were responsive to changes in their needs. For example, one person said, "They made sure I had extra help when I was not feeling too well. I didn't tell them but (Staff member) noticed I wasn't myself and suggested she help me. That's the reason I'm here, because I know I need more help now." A relative told us they had confidence that staff would notice any changes, they said, "I think they are on the ball in that way, they look for changes all the time." A staff member said that care plans were updated regularly and when there was a change in a person's needs. They told us, "Care plans are kept up to date and any changes are communicated to staff during handover to ensure we are all aware." Records of handover meetings confirmed this.

Some people had communication difficulties and their care plans included strategies to ensure their communication needs were met and that they were not excluded from elements of life at the home such as group activities. One person had a communication passport which included relevant information about the person's disabilities including how their ability to communicate was affected. Guidance included prompts for staff and others in how to use the communication tool. Staff told us the use of visual pictures and diagrams was 'work in progress' and they would continue to develop the tool and adapt it to be more person centred as the person became more familiar with its use. Another person was living with sensory

loss which affected their sight. Staff told us that they had obtained talking books for the person to ensure they could continue to enjoy the books they liked.

Staff told us that people were supported to maintain relationships that were important to them. For example, one person was supported to visit her husband on a regular basis at another care home. Relatives told us that there were no restrictions on when they could visit and that they were made to feel welcome. One relative said, "I come every day and they (staff) always seem pleased to see me." Relatives said that staff kept them informed of what was happening and that staff were approachable and helpful.

People told us that they enjoyed the activities that were on offer at the home. We found that there was a wide range of organised activities arranged by dedicated activities co-ordinators. We observed a number of activity events happening in different areas of the home and saw that staff were encouraging people to join in and supporting them to be involved. Records showed that people also received dedicated time on an individual basis if they wanted to. We observed people enjoying a ball game, taking part in arts and crafts and music sessions. Staff told us that some people were able to go out independently and there were limited opportunities for people who needed staff support to access the local community. Staff had made links with a local nursey school and told us that people enjoyed visits to the nursery every week for an intergenerational club. A staff member told us that residents from different areas of the home would attend some sessions together such as for the music and movement group and for religious services that were held at the home by representatives from local churches. One person told us that they enjoyed walking in the grounds of the home and reading quietly in their bedroom. They said, "I like doing my own thing, I can join in the activities when I want to, I like the exercise and bingo because it's a good way of mixing and it's fun." Another person told us, "The staff are really enthusiastic and always encourage people to join in. I get involved in some things because it passes the time and I would be bored otherwise."

People and their relatives knew how to raise complaints and said they were confident that actions would be taken. One relative told us about an issue they had raised saying, "I think they understood and will respond." Another relative told us they felt comfortable to talk to the staff, they said, "There's no barriers with the staff, they are always helpful." One person said they would tell any of the staff if they had a concern and another person said, "I would speak to the manager." Any complaints were recorded with the actions taken to resolve the issue and the registered manager had oversight of the complaints process to ensure learning was used to make improvements to the service.

People were supported to make plans for care at the end of their life. This included recording their wishes about where they would prefer to die and any particular spiritual or cultural needs. Staff members told us that they had developed good relationships with staff at a local hospice. Records confirmed that a specialist nurse from the hospice had provided advice about an end of life care plan. Staff spoke knowledgeably about provision of end of life care. One staff member spoke with compassion about the importance of creating an environment for people to pass away peacefully and for their family members to be as involved as they wanted to be. They told us, "We can make a difference with the right planning, making the room as comfortable as possible, having music playing quietly to create a calm atmosphere and above all making sure people's symptoms are controlled." Another staff member spoke about ensuring practical arrangements were in place such as having all the medicines that might be needed in place and making sure staff levels were adjusted to enable a staff member to sit with the person who was at the end of their life.

Two staff members spoke about how they had been involved in caring for a person at the end of life who had particular cultural and religious needs. One staff member described how they had spoken to the person's family to ensure they could accommodate the person's wishes and needs. Another staff member described it as a positive experience and spoke proudly of how staff members had been able to support the

person and their family. Staff told us they received the training and support they needed to provide end of life care effectively.

Requires Improvement

Is the service well-led?

Our findings

People, their relatives and staff spoke highly of the management of the home. Their comments included, "It's very well run," and, "I get on well with the manager of the unit," and, "I have no complaints, the place is well managed." One relative told us, "I think they do a good job." Not everyone we spoke with knew who the registered manager was. Some people recognised the manager of the nursing unit but did not know who the overall home manager was. One person told us they did not know who was in charge and another said they would ask for the manager at reception because they were not sure. We noted that there were photographs of staff members in hallways around the home to help people to identify who staff were. Staff members told us that the registered manager was often present in all the units they worked in. One staff member told us, "We see a lot of (registered manager), they are always available to talk to and very approachable." Another staff member said, "Senior managers will help out when needed, we are a very good team." A third staff member said of the registered manager, "They are very caring, like everyone's mum." However, despite these positive comments we found some areas of practice that needed to improve.

The provider had a range of systems and processes to ensure good governance. A number of audits monitored quality and management oversight and analysis of complaints, incidents and accidents, helped to drive improvements. However, not all systems were effective in identifying shortfalls in practice. For example, staff were not consistently complying with the provider's medicine policy and this had resulted in a medicine administration error and failure to ensure medicines were stored safely. Governance arrangements had not identified these errors.

There was not always an effective process in place for monitoring and recording the use of PRN (as required) medicines in some areas of the home. The provider's medicine policy did not provide guidance for staff in use of PRN protocols. A review of the medicine policy in 2016 had not identified this omission. This had led to inconsistent practice across the home, with some team managers implementing effective PRN protocols and others having no protocol. The registered manager took immediate action to address these omissions and the governance arrangements were reviewed and updated by the second day of the inspection. We identified these areas as requiring improvement to become embedded and sustained within practice.

There was a lack of effective systems in place to monitor the support people received and their experience in receiving the support. Our observations and feedback from people, their relatives and staff members confirmed that deployment of staff was not always effective in providing a timely response to people's needs. Systems to monitor staff response to call bells were not adequate to provide the registered manager with assurance that people were receiving the support they needed in a timely way.

Some records were not complete and accurate. For example, some care plans did not include clear documentation relating to issues of capacity and consent. Some care plans lacked detail such as background information to give a clear picture of the person whilst other care plans contained more comprehensive information. Pressure mattresses were in use to reduce risks to skin integrity. Staff told us that they were maintaining regular visual checks of the mattress in line with guidance in people's care plans. However these checks were not being recorded, this meant that the registered manager could not be

assured that the required checks were undertaken consistently.

There was a lack of effective systems to monitor and improve the safety and quality of services, and not all records were accurate and complete. This is a breach of Regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

There was a clear leadership structure with identified management roles. Each area of the home had a dedicated manager and senior staff who supervised nurses and care staff. There were also dedicated managers for support staff providing catering, housekeeping and facilities services. The registered manager held daily management meetings to retain an overview of all areas of the home. Staff members also attended team meetings on a regular basis according to the area of the home where they were based. Staff told us that they understood their responsibilities and knew what was expected of them. One staff member said, "Communication is good here, we all know what we should be doing." The registered manager described being well supported by the provider and explained how strategic decisions were taken by the management committee of trustees for the charity.

The registered manager understood their responsibilities. Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The care manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. They were aware of the revised Key Lines of Enquiries that were introduced from the 1st November 2017.

The registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment. We noted that when a medicine administration error was noticed during the inspection the registered manager took immediate action to address the error and to comply with the Duty of Candour requirements.

Staff described an open culture at the home where they felt comfortable to raise concerns and contribute ideas to the development of the service. One staff member said, "We can add our views, for example, when we think something needs changing or doing differently we discuss it at a team meeting." Another staff member said, "It's a close staff group and there is openness. We celebrate achievements as well." Notes from staff team meetings showed that staff were regularly contributing to discussions.

The provider engaged with people and their relatives to help drive improvements at the home. They used a number of methods to gain feedback from people and their relatives. One relative told us, "I have had satisfaction surveys and we have relatives meetings where we can put forward our suggestions or ideas." Another relative said, "We get the chance to bring up anything that needs sorting out at relatives' meetings." A staff member told us that residents meetings were held regularly and people's views were always given consideration. They said, "We are always trying to improve things, for example at the residents' meeting people said the TV was too small so they have got a much larger one now."

The provider had plans for the ongoing development and sustainability of the home. The registered manager explained how they were working with the provider's board and trustees to take their vision forward and ensure sustainability of their model.

Staff members had made links with the local community and had developed partnerships with a number of local services. This included with the GP surgery and pharmacy, the local ambulance service, a local

hospice, a nursery and local schools and colleges. Staff told us that people benefited from these links in a number of ways. For example, work experience placements had been offered to young people, some with special needs, and this provided additional support for activities and socialising. During the inspection we observed two young volunteers interacting with people as part of these arrangements and noted that people were engaged and clearly enjoying their company.

The registered manager told us that meetings of a local Older People's Forum and the Dementia Alliance were regularly held at the home, as well as a Volunteers Forum. They explained that this provided a number of benefits including opportunities for volunteer recruitment as well as having involvement in local developments and initiatives for older people and keeping up to date with best practice both locally and nationally.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Staff were not consistently following the provider's policy and procedures for managing medicines safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not always effective in monitoring and improving the safety and quality of services.