Abbey Health Care Limited

Abbey Court Nursing Home - West Kingsdown

Inspection report

School Lane
West Kingsdown
Sevenoaks
Kent
TN15 6JB

Tel: 01474854136

Date of inspection visit:
07 April 2016
08 April 2016

Date of publication:
14 June 2016

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection was carried out on 07 and 08 April 2016 by two inspectors and a specialist advisor. It was an unannounced inspection. The service provides personal and nursing care and accommodation for a maximum of 22 older people and people living with dementia. There were 19 people living there at the time of our inspection. One person was on respite for a short stay. Some people were able to communicate with us directly. Some people were not able to express themselves verbally due to their health needs.

There was a registered manager in post. 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 our last inspection on 29 June 2015 the service was placed in special measures. The purpose of special measures is to ensure that providers found to be providing inadequate care significantly improve. This also provides a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

At this inspection we found the registered manager had made significant improvements to the service. They had worked with the local authority to improve standards of care and practice. We have judged the service is no longer in special measures. Whilst significant improvements have been made, there are further areas identified for improvement. We will inspect the service again within 12 months to ensure the provider has made the required improvements.

People had care plans to record the care and treatment needs. Although staff had updated evaluation records every month, people's care plans did not always reflect people's most current needs.

People received prescribed medicines from staff who had been trained in medicines management. However, guidelines were not in place for staff to administer people's PRN (as required medicines) and topical medicines safely. Although we did not identify poor outcomes for people, the lack of guidelines could increase the risk of people not receiving PRN medicines in line with people's individual guidelines. We have made recommendations about medicines management. The registered manager was responsive to making the necessary improvements.

Where the responsibility for people's care and treatment was shared with other people to include health care professionals, one person's review of care had not taken place in a timely way. Whilst improvements had recently been noted, we have made recommendations about improving joint working protocols.

We have made a recommendation that 'All About Me' documents are completed to support effective handover with external health professionals in the event people are admitted to hospital.

Staff training was renewed annually, was up to date and staff had the opportunity to receive further training specific to the needs of the people they supported. Staff completed training in dementia awareness. The registered manager had plans to develop staff knowledge and competence in dementia care practice. We have made a recommendation about dementia practice.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. At the last inspection in June 2015 improvements were needed to ensure people were not unlawfully deprived of their liberty and had their right to make decisions upheld. At this inspection we found improvements had been made. The registered manager understood when an application should be made and how to submit one. We have made a recommendation to further develop this practice.

At the last inspection we made a recommendation that suitable signage and environmental items of benefit for people living with dementia are provided in line with current guidance. At this inspection the registered manager had acted on this and had made improvements to the environment. We have made a recommendation about further improvements to the premises.

People had advance care plans in place. These provided general information on people's end of life decisions, with the focus on resuscitation status and preferred place of care. The staff had a good rapport with relatives to support end of live planning to enable people to have choices at the end of their life. We have made a recommendation to ensure people's preferences and individual wishes are recorded about their end of life care.

We observed positive interactions between people and staff where people were living with dementia. Care plans recorded some guidance as to how staff should communicate effectively with each person using person centred methods. We have made a recommendation about further development of people's care plans.

At the last inspection we made a recommendation that meaningful activities needed to be considered for people living with dementia. At this inspection the registered manager had acted on this and had implemented an activities programme based on people's wishes and preferences and had recorded activities that people took part in. The registered manager told us they were continually developing their activities programme.

The registered manager carried out audits to identify how the service could improve. The registered manager had significantly improved the audit system since our last inspection and additional audits had been implemented. However, some shortfalls we found during the inspection had not been identified as part of the audit process. The registered manager was responsive to taking the necessary measures to continuously improve the quality of the service and care.

At the last inspection improvements were needed to infection control. At this inspection cleaning schedules had improved. They contained a good level of detail to enable the registered manager to monitor which areas of the home had been cleaned each day. People were protected from the risk of cross infection. Hand wash facilities were available in all toilets and bathrooms and the premises were observed to be clean.

At the last inspection improvements were needed to fire safety. At this inspection all fire protection equipment was serviced and maintained. Personal Emergency Evacuation Plans PEEPs were in place for people to guide staff and emergency services as to how people would be supported to vacate the premises in the event of a fire.

Staff were trained in how to protect people from abuse and harm. They knew how to recognise signs of abuse and how to raise an alert if they had any concerns. People told us, "Nothing bad happens here, the staff make sure we feel safe, they watch over us."

There were sufficient staff on duty to meet people's needs. There were safe recruitment procedures in place which included the checking of references.

All members of care staff received regular one to one supervision sessions and had an annual appraisal to ensure they were supporting people based on their needs and to the expected standards.

People gave us positive feedback about the food and drink available to them. At the last inspection improvements were needed to ensure people had a positive dining experience. At this inspection the dining experience was adequately adapted to the needs of people living with dementia.

Staff communicated effectively with people, responded to their needs promptly, and treated them with kindness and respect.

People were able to spend private time in quiet areas when they chose to. People's privacy was respected and people were assisted in a way that respected their dignity.

The staff promoted people's independence and encouraged people to do as much as possible for themselves.

The registered manager sent satisfaction surveys to people, their relatives or representatives and recorded what action had been taken to develop the service in light of people's feedback.

The registered manager notified the Care Quality Commission of any significant events that affected people or the service.

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 were supported to take their medicines by staff trained in medicines administration. PRN and topical cream protocols were not in place to ensure people's medicines were administered as required. We have made a recommendation about PRN protocols.

The registered manager had personal emergency evacuation plans in place for all people at the home to record how people could safely evacuate the premises in the event of an emergency.

People were protected from the risk of cross infection. Cleaning schedules contained sufficient detail to enable the registered manager to monitor which areas of the home had been cleaned each day. There were adequate handwashing facilities available and the premises were clean.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The registered manager understood when an application for DoLS should be made and how to submit one. We have made a recommendation to develop this practice further.

Suitable signage and environmental items of benefit for people living with dementia were provided in line with current guidance. We have made a recommendation about further improvements to the premises.

Staff training was renewed annually, was up to date and staff had the opportunity to receive further training specific to the needs of the people they supported. Staff completed training dementia awareness. The registered manager had plans to develop staff knowledge and competence in practice. We have made a recommendation about dementia practice.

People gave us positive feedback about the food and drink available. The dining experience was suitably adapted to meet the needs of people living with dementia.

Is the service caring?

Good

The service was caring.

Staff communicated effectively with people, responded to their needs promptly, and treated them with kindness, compassion and respect.

Staff promoted people's independence and encouraged them to do as much for themselves as they were able to.

People's privacy and dignity was respected by staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans for people living with dementia included some guidance on how to encourage people and staff to communicate effectively with each other. We have made a recommendation about development of care plans.

There were adequate meaningful activities available for people and for those people living with dementia. The registered manager had implemented an activities programme based on people's wishes and preferences and had recorded activities that people took part in.

The registered manager sent surveys to people, their relatives or representatives and had recorded what action had been taken in light of people's feedback to develop the service.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a quality assurance system in place. The registered manager had made improvements since the last inspection. However some shortfalls we identified at this inspection had not been identified as part of the provider's audit.

The culture at the home was welcoming and there was a sense that staff genuinely cared for and respected people. The registered manager was motivated and committed to providing care to people in a compassionate and caring way.

Abbey Court Nursing Home - West Kingsdown

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 checked 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 was carried out on 07 and 08 April 2016 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor with direct experience and knowledge of working with people living with dementia.

The registered manager had completed a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We gathered this information during the inspection. Before our inspection we looked at records that were sent to us by the registered manager or the local authority to inform us of significant changes and events. We reviewed our previous inspection reports.

We looked at records which included those related to people's care, staff management, staff recruitment and quality of the service. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We looked at the activities programme and the satisfaction surveys that had been carried out. We sampled ten of the services' policies and procedures.

We spoke with eleven people and three relatives to gather their feedback. We also spoke with the registered manager, the matron, the activities co-ordinator the cook and four members of care staff. After the inspection we received written feedback from one professional with direct knowledge of this service.

Requires Improvement

Is the service safe?

Our findings

People told us, in relation to how safe they felt, "Yes I do feel very safe here, because there are people around; all I have to do is call and they [staff] will come" and "I don't have long to wait if I call them [staff]" and "I am in safe hands I reckon." One person told us, "They [staff] are there to catch me if I fall" and "I am looked after here, I wasn't feeling safe in my old home." Relatives told us, "We feel our relative is safe here because there is 24 hour care and always staff available to help them" and "Knowing our relative is here gives us peace of mind." One relative wrote, "It meant a lot to us to know that X was in a safe and secure environment." Comments taken from a relative's survey read, 'Mum is safe and in good hands' and 'If staff are concerned they take all measures of quality care and nursing steps' and 'I have no concerns about how well X is being looked after.'

People were supported to take their medicines by staff trained in medicines administration. Staff had their competency assessed by the registered manager every six months or when required. Records showed that staff had completed medicines management training. Audits of Medicine Administration Records (MAR) demonstrated that people had medicines as prescribed. Each person had a medication administration record (MAR) front sheet with a current photograph of the person. This ensured each person was correctly identified before staff administered medicines. People's allergies were clearly specified. We looked at 18 MAR charts. There were two gaps in one MAR, the medicines had been given but not signed as given. All other MAR charts were fully and accurately completed demonstrating people received their prescribed medicines safely.

We have identified areas for improvement in medicines management. Where people were prescribed medicines 'as required' there were no PRN protocols in place. The PRN protocol is a standard document used to inform staff how to administer people's PRN medication. The provider's medicines policy stated, 'PRN instructions must be made available to the care worker and placed in the person's records next to the MAR. The care worker must consult PRN instructions before administration of the medication.' There was a PRN protocol template within the provider's policies file, however, this was not being used. Although we did not identify poor outcomes for people, the lack of information on the PRN forms and people's care plans could increase the risk of people not receiving PRN medicines safely or in line with their individual guidelines. Topical MAR charts were not in place where people needed creams applied. Although we did not identify poor outcomes for people, the lack of clear guidelines could increase the risk of people not receiving the creams they needed at the correct times.

The provider had policies and procedures in place for medicines management. However these were not always written in plain English which could result in misinterpretation by the staff. Although we did not identify poor outcomes for people, in some cases specific information about potential risks associated with people's medicines was not recorded in their care plans. This included the possible increased risk of skin tears due to skin fragility, and the importance of not stopping the medication without a period of reducing the dosage. The registered manager and matron were responsive to recommendations made and told us they would make the required improvements.

We completed an observation of the administration of medicines morning round. Medicines were administered to people using a spoon and staff offered people water. When the nurse went to the second person they used the same spoon which had not been cleaned. We observed the nurse administering medicines did not wash their hands between each person they administered medicines to. This increased the risk of transferring infection from person to person. The matron later explained they normally have a number of spoons and a bowl of water to put used spoons in. We observed they prepared this at the next medicine round and had ensured good infection control practice. We observed on one occasion that staff had not followed the provider's policy on the safe administration of controlled drugs (CD). The policy states, 'If administering a CD a second person should witness the administration then sign the record.' Both staff members signed the CD book before one person had taken the medicine and the nurse went alone to administer the medicine, instead of taking a second person to witness this in line with best practice.

The registered manager was able to describe how they assessed people for pain. These assessments were personalised although they did not specify the language a person might use if they were to describe their levels of pain. For those people who have difficulty expressing their pain, for example people living with dementia, the use of a pain scale tool such as the 'Abbey Pain Scale' or 'Doloplus' helps the person administering medicines to make and record an informed choice in line with best practice.

We recommend the provider reviews policies and procedures for medicines management and ensures staff are competent and follow best practice.

There was an adequate number of staff deployed to meet people's needs. The registered manager completed staff rotas in advance to ensure that staff were available for each shift. There was an on-call rota so that staff could call a manager out of hours to discuss any issues arising. Our observations indicated that sufficient staff were deployed in the service to meet people's needs. The staff told us that there were sufficient numbers of staff on shift. We observed the staff were not rushed, supported people in a calm manner and were able to spend time talking with people. As staff covered additional shifts in case of sickness no agency care staff were used, which meant people were cared for by staff who knew them.

Policies and procedures were in place to inform staff how to deal with any allegations of abuse. Records showed that staff were trained in recognising the signs of abuse and they were able to describe these to us. Staff understood their duty to report concerns to the registered manager and the local authority safeguarding team. There were posters on the wall in the nurse's office to explain how staff should report safeguarding concerns. Safeguarding policies had been discussed in staff meetings. Contact details for the local authority safeguarding team were available to staff if they needed to report a concern. There was a whistleblowing policy in place. Staff told us they would not hesitate to report any concerns they had about potentially poor care practices. However the whistleblowing policy did not provide staff with contact details of external agencies they could contact in the event staff wished to report concerns. The registered manager told us they would ensure the policy was updated to include this information.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the service. These included employment references and Disclosure and Barring Service (DBS) checks to ensure staff were suitable. Nurse staff had the required registration in place to carry out their nursing role and responsibilities. Staff were subject to a probation period before they became permanent members of staff. Disciplinary procedures were followed if any staff behaved outside their code of conduct. This ensured that staff were of good character and fit to carry out their duties.

At the last inspection on 29 June 2015, Personal Emergency Evacuation Plans (PEEP) were not in place for all people. The PEEPs identified people's individual independence levels and provided staff and emergency

services personnel with guidance about how to support people to safely evacuate the premises. At this inspection improvements had been carried out. PEEPs were in place for all people. The PEEPs recorded people's level of mobility, mental capacity, and sight or hearing needs and equipment needed to help people safely leave the premises. Evacuation drills were completed regularly to support people and staff to understand what to do in the event of a fire. Evacuation drills had been completed in the day and at night to ensure staff on different shifts understood what to do in the event of a fire. All staff had attended fire safety training and first aid training. The fire alarm was tested weekly and all fire equipment was serviced every six months. The registered manager had put in place a 'grab bag'. This contained information for staff and emergency services personnel to support safe evacuation of the premises and items of importance in the event of a fire. These systems meant that staff were in a position to protect people in the event of an emergency such as a fire.

There was a business contingency plan in place that addressed possible emergencies such as extreme weather, infectious diseases, damage to the premises and loss of utilities. Procedures were in place to ensure continuity of the service in the event of adverse incidents. The premises were kept secure and were protected from inappropriate access.

Portable electrical and gas appliances were serviced regularly to ensure they were safe to use. All equipment that was used to help people move had been regularly serviced to include the lift, hoists, nurse call bells, and emergency lighting. The bathrooms were equipped with aids to ensure people's safety. Handrails were in place to help people walk around the premises safely. People were escorted by staff when they needed to access other floors. We observe staff using equipment to help people move around and staff followed appropriate procedures to ensure people were safe.

Records of accidents and incidents were kept at the service. When incidents occurred staff completed physical injury forms, informed the registered manager and other relevant persons. Accidents and incidents were monitored to ensure risks to people were identified and reduced. One incident occurred where someone had a fall. Staff referred the person for a blood test to evaluate whether there was any physical health reason for this. Staff referred the person to the falls clinic for a review of their needs. Risk management measures were taken to reduce the risk of incidents occurring and people's care plans were updated with any changes made.

Care records contained individual risks assessments and the actions necessary to reduce the identified risks. One person had a risk assessment and control measures in place due to the risk of falls. Two staff members supported the person to transfer from chair to sitting to standing position. The person was provided with a hoist to help them with all transfers and the size of hoist needed was recorded in their care plan. The person had a walking frame to support them to walk. Several people have sensor mats within their rooms to alert staff if they get up to move around so they can go and assist them. There was a falls policy in place which gave staff clear guidelines on what to do in the event someone had a fall. A relative told us, "When my relative had a fall, I was informed by telephone within the hour and by the time we came all precautions had been taken and they haven't fallen since."

At our last inspection on 29 June 2015, we found the systems to monitor infection control were not fully effective. At this inspection, we checked that cleaning schedules were appropriately documented and monitored. Improvements had been carried out and daily cleaning records were kept for each room in the house and all equipment used including hoist slings. These records were up to date and were checked by the registered manager weekly. The registered manager carried out daily spot checks in the home. We looked at eight bedrooms, one bathroom and one shower room. These were clean, tidy, and free of waste. We inspected six commodes, four hoists, six wheelchairs and the armchairs in the lounge. They were clean

and well maintained.

The registered manager carried out regular audits to monitor infection control in the home. These included an environmental cleanliness check every two months; a quarterly laundry audit to check appliances, storage, clothes labelling, the segregation of clean and soiled items, ironing and staff training and a further bi-yearly audit to identify possible improvements to the cleanliness and maintenance of the home. When audits had identified a shortfall, for example the need for a toilet roll dispenser to be sealed and for a room to be deep cleaned ahead of schedule, the provider had taken action to address the shortfall. The registered manager had provided staff with a summary of the home's policy on infection control, which included clear guidance about the segregation of laundry and how to apply this in practice. Reminders for staff were displayed above each laundry bin. There were hand hygiene posters above each sink. We observed staff wearing personal protection equipment and washing their hands before they helped people. The registered manager completed a 'hand hygiene compliance audit' monthly. As a result, more posters on hand hygiene had been purchased and displayed and a bar soap had been replaced with a soap dispensing system to keep people safe from the risk of contamination.

Requires Improvement

Is the service effective?

Our findings

People told us, "The staff are OK, they know me so they give me what I like" and "If I want to eat something else they [staff] give it to me" and "They [staff] know me well, we understand each other." Relatives told us, "We get notified whenever anything changes, the communication is good." Staff ensured they communicated effectively with people. A person had difficulties understanding what was being said and staff spoke gently closer to their ear, whilst maintaining good eye contact with the person. Staff ensured the person had understood what was said and gave them time to respond. Staff talked with someone while they used equipment to help them move from a wheelchair to an armchair. They provided explanations of what they intended to do before they did it and checked the person understood and consented. Reassurance was provided in a kind manner when a person became particularly anxious before being moved. One of the two members of staff smiled at the person, held their hand and told them in a calm tone, "No worries, we are all here to help, you will be absolutely fine." This was effective in reducing their anxiety.

One relative wrote to the provider, "Mum was only with you for a few weeks but we were very impressed with the level of care from all members of staff." Another relative wrote, "Thank you for the fantastic care X received. They instantly settled in on arrival due to the friendly and relaxed atmosphere. X very much appreciated the high level of care they received; telling me on several occasions how well they were being looked after." Comments from a relative's consultation read, 'I believe Mum could not get better care' and 'Issues are communicated in a suitable way' and 'Staff are very competent so we are put at ease.'

We identified improvements to care records had been made since the last inspection in June 2015. However, we found further improvements were required to ensure records reflected people's most current needs. Records showed that one person was eating well when they initially come into the home and they had gained weight which was positive for them. Staff had referred the person to a dietician for an assessment of their nutritional needs. Their nutrition was being monitored daily with a food chart and monthly weights checks in place. We observed staff assisted people to have regular meals and snacks throughout the day. Although we did not identify poor outcomes for the person, there was no recorded information in their care plan about how staff should support the person to have adequate food and drink.

Staff had provided effective support to one person with a pressure sore. The wound had healed well. Over time the person had developed other sores which staff had effectively treated. However, it was difficult to track the progression of these pressure sores. Although we did not identify poor outcomes for the person, photographs of the person's pressure sores had not been regularly taken and recorded to reflect the progression or deterioration of healing. People had been assessed using the Waterlow scale for risks of skin breakdown for a pressure relieving mattress and cushion in line with best practice. The Waterlow scale gives an estimated risk for the development of a pressure sore in a patient. However in one case, it was not recorded in the person's care documentation what setting the pressure relieving equipment should be set at. Although we did not identify poor outcomes for the person, staff had not recorded how the pressure relieving equipment should be used effectively in this case.

One person had recently been visited by the G.P to monitor their diabetes condition. We observed people

were given meals that considered their diabetic needs. For example, we observed during lunchtime people were offered a choice of a diabetic dessert. The chef had guidelines in the kitchen on people's nutritional requirements to ensure people's nutritional needs were met. Although we did not identify poor outcomes for the person, there was no specific information about the person's dietary requirements in their care plan. People were visited by health care professionals such as chiropodists and these visits were recorded in people's care plans. However for this one person, there was no information recorded about the person's nail or foot care which is associated with this health condition.

In some care plans the care described did not always reflect current assessed care needs, although this information was recorded within the evaluations section of the care plan, which were reviewed every month. Some of the care plans were over two years old and whilst they had been evaluated reflecting changes, the care plans had not been updated. This may make it difficult for staff to find current information about people's care and treatment needs. Care staff relied on either using out of date information from the care plan or having to find the updates in the evaluations which have often been archived. Evidence of regular care reviews including people and their next of kin was not consistently recorded in people's care plans.

This lack of accurate and up to date care plan information is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance.

Staff referred one person to the Tissue Viability Nurse (TVN) on 09 March 2016 for assessment as they had developed a pressure sore. On 14 March 2016 the TVN responded that the person should be referred to podiatry as it was a foot wound. The G.P. had been involved and had made suggestions and prescribed different dressing types and recommended the person kept their legs elevated when sitting in a chair. The specialist advisor observed an improvement in documentation and support since March 2016. Although we did not identify poor outcomes for the person, the delay in getting TVN input could have contributed to prolonging the process of healing.

We recommend the provider reviews joint working protocols where the responsibility for people's care and treatment is shared with other health care professionals.

People's wellbeing was promoted by regular visits from healthcare professionals. The GP has been actively involved in meeting people's medical needs. A chiropodist visited people to provide treatment and an optician and a dentist visited when required. Emergency services had been called when necessary. People said that if they were not well a doctor would be called. A relative said that their loved one saw the doctor regularly. Records about people's health needs were kept and information was effectively communicated to staff so effective follow up was carried out. There was no evidence within the care files of a transfer document or 'All About Me' document which is recommended by the Alzheimer's Society for people living with dementia in the event they went to hospital.

We recommend the registered manager completed 'All About Me' documents for people to support effective handover with external health professionals in the event people are admitted to hospital.

All staff had received training in dementia care awareness. We observed positive interactions between people and staff. Staff showed patience and understanding, explained what they were doing to support people and used visual aids to support people's understanding and help them makes informed choices. However some staff we spoke with were not confident in explaining how they supported people living with dementia. The registered manager had undertaken recent leadership training in dementia care and had plans to share this knowledge with staff to develop best practice in dementia care. The Matron was open to changes of approach and new learning for people living with dementia. They said, "If it makes the lives of

people living here better then we need to learn more." One staff member talked to us about how training they received in 'dementia awareness' helped them support someone living with dementia. They told us, "I have had training in dementia awareness. This told us about people's experiences of having dementia and behaviours they may have." We asked them how they put their dementia awareness training into practice. They told us, "I check people's mood and where there are signs they do not want something I try later. I take time with people and observe their body language to assess their mood." Staff talked to us about different communication methods they used with people living with dementia. They told us one person responded well when staff used short sentences and key words. Staff said the person really enjoyed their food. At times the person needed encouragement with personal care. Staff talked to them about food they liked which tended to motivate to engage with staff when receiving support with personal care tasks.

We recommend the provider further develops staff awareness and develops practical implementation of staff training around the needs of people living with dementia.

Staff had training and professional development options available to them. Staff were supported to achieve further qualifications in social care. The registered manager had put in place a training plan to ensure staff training remained up-to-date. This system identified when staff were due for refresher courses. Staff attended formal annual appraisals of their performance and career development. The registered manager had a plan to ensure staff received regular supervision and this was taking place. Supervision records contained information about staff training, performance and development needs. For example one supervision record read, 'Residents find staff member X helpful, kind and confident.'

Staff had an induction when they began working at the home and had demonstrated their competence before they had been allowed to work on their own. The registered manager had implemented the new 'Care Certificate' training to be used with all new staff since April 2015. This is based on an identified set of standards that health and social care workers adhere to in their daily working life. It has been designed to give everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care. The Care Certificate was developed jointly by Skills for Health, Health Education England and Skills for Care. Staff competence in meeting the requirements of the Care Certificate was assessed by the registered manager. Staff recorded information on all aspects of their care practice to enable them and other staff to discuss good practice and any areas for improvement.

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 is called the Deprivation of Liberty Safeguards (DoLS). At our last inspection dated 29 June 2015, we found that the staff and management had not gained an adequate understanding about how to apply the MCA in practice.

At this inspection, we checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Related assessments and decisions had been properly taken. The registered manager had carried out improvements in assessing people's mental capacity as per the MCA requirements. The registered manager and staff had completed additional training about MCA and DoLS in October 2015. Staff were provided with guidelines in an information folder about the MCA and what it meant in practice. This included guidance from the Social Care Institute for Excellence (SCIE) and the Care Quality Commission, as well as presentations from qualified trainers. This file was accessible to staff and staff had signed a checklist to evidence they had read and

understood the content.

Staff demonstrated a good knowledge of the principles of the MCA and how to apply them in practice. People told us that staff obtained their consent before providing them with care. Staff sought and obtained people's consent before they helped them. One staff member told us, "I know X's likes and dislikes. I use key words and short sentences to communicate with them [to help them understand]. They tell me when they don't want something. They will say to me 'leave or 'don't want' I tend to leave them and return a little later and try again." One staff member told us, "When people do not have mental capacity, I would talk to the manager and the person's family. We have meetings to make decisions in people's best interests." When people declined to do something, for example when they did not wish to get up or go to bed, their wishes were respected and staff checked again a short while later to make sure people had not changed their mind.

We sampled seven people's care files. They contained a record of how people's mental capacity had been assessed. Where people had capacity they had signed to confirm they had been involved in care planning and agreed to their care plans. Mental capacity assessments were in place with regard to their ability to consent to their daily care or specific treatment, for example to be administered medicines, to having bed rails in place to keep them safe or to having their photographs taken. The assessments also considered an update of the legislation following a Supreme Court ruling in April 2014. This addressed people's mental capacity when they were not free to leave unaccompanied and when they were subject to constant supervision.

The registered manager had submitted two DoLS applications to the appropriate authority. One person had a risk assessment in place for the use of a safety belt when sitting in their chair to keep them safe. Staff recognised that this was a deprivation of the person's liberty and had completed the statutory application for a standard legal authorisation for this. The registered manager had sought guidance from the local authority. They were in the process of assessing more people in the service to determine whether to submit further DoLS applications.

Two people have sensor mats within their rooms to alert staff if they get up to move around the room, as they have been assessed as high risk of falls. The use of sensor mats for people represents constant supervision. Both people have been assessed to lack mental capacity. This level of supervision had not been included within the provider's DoLS assessment. Technically this is a form of unlawful restraint. There was no information in those people's care plans to identify what the least restrictive option would be in relation to these restrictions balanced with the risks posed to them.

When people had the mental capacity to make their own specific decisions about their care and treatment, this was appropriately documented. When it had been identified that a decision had to be made on their behalf in their own interest and to keep them safe, meetings had been held to decide the best way forward, considering the least restrictive options for people. In one person's care plan staff recorded a best interests meeting which was held on 16 January 2016. It was discussed as to whether or not cardiopulmonary resuscitation (CPR) should be performed in the event the person experienced cardiac or respiratory collapse. However, there were no outcomes recorded from the meeting. It was difficult to establish what the true purpose of the meeting was, what was hoped to be achieved and if there was an outcome.

We recommend the provider reviews DoLS applications for people and best interest meetings to further develop the application of the MCA in practice.

At our last inspection dated 29 June 2015, we found that the dining experience was not suitably adapted to

the needs of people living with dementia or experiencing confusion. Information for people was not provided in an appropriate format to help people understand menu options available to them. For example, when people were asked what they preferred to eat, staff did not help them decide by showing pictures of food or photographs. The menu was written on a board without pictures to help people identify the meal. We observed staff offered people two options of dishes and automatically selected the main dish on offer when people did not respond, which may not have supported their choices or preferences.

At this inspection the registered manager had carried out improvements to ensure people had a positive dining experience. There was a pictorial menu displayed in the lounge with photographs of the main dishes that were on offer. The registered manager showed us a book of photographs of food that they used to support people to decide on meal options that they chose each morning. If there was nothing on the menu the person liked, the cook would change things to suit people's needs. There was a choice of main meal and an alternative meal was prepared when people preferred. People were able to have second helpings and various drinks as they wished. There were two desserts available. A choice of water or juice was offered to people and this was refilled as needed. Some people had plate guards to enable them to eat their meals independently and with dignity. People were being provided with drinks and snacks throughout the day. People acknowledged when asked by staff that they had enjoyed the meal. One person ate in their bed and we noted how they had difficulties scooping up the food. Within four minutes of the food being served, a staff member was there to assist the person and remained with them until they had finished. One staff member told us, "I encourage people to eat and assess their independence to do this. There are jugs of water kept in people's rooms and the lounge. I regularly check people have enough water. People can have a choice of snacks during the day."

People had positive views about the food provided at the home. One person said, "Nice meal" and "Very nice. Apple pie I am being spoiled!" Several people commented that they had enjoyed the food. During lunchtime the meal was freshly cooked, well presented and looked appetising. It was hot and in sufficient amount. Condiments were available. Four people ate independently at a table. One person told us, "This is our table, so it's cosy for us." The registered manager regularly consulted with people and their relatives to ensure people's food and drink preferences were met.

We spoke to the cook. They told us they were adaptable to people's needs. They said, "People tell me what they want. If people don't like something we take it off the menu. Some people have requested spicy food. X likes curries. People tell me when they would like something new on the menu. We always monitor people's needs. Some people have cream and cheese in their meals and some people need their meals fortified. We use full fat milk. X told me they liked café lattes and scrambled eggs for breakfast. People's allergies, dietary restrictions and preferences were made known to the cook. Some people have specific requirements which we meet. There is always fruit and fresh snacks available."

At our last inspection on 29 June 2015, we found that adaptations to the premises were not in place to support the needs of people living with dementia. There was no information displayed about activities taking place or which staff were on duty to minimise confusion for people living with dementia or to help people understand options available to them. Visual aids and signage were not in place to support people living with dementia to find their way around their home or to help them understand and make choices about what was available.

Although improvements had been made to the premises since the last inspection, we found two areas where improvements were required. One communal room could not be used as equipment was stored in it. Lighting in the corridors was not always on and there was a sign in the care office to remind staff to switch off unnecessary lights. Lighting in corridors and bedrooms is important for everyone including people living

with dementia and age related vision loss. This minimises the risk of falls and maximise people's independence and confidence when moving around.

At this inspection, the registered manager had carried out a number of improvements to the premises to adapt them to the needs of people living with dementia. They had put laminated signage in place to help people find their way around. People's bedrooms had their names in a large font and some had pictures of the person on them and others had pictures of things that they enjoyed from their past. This supported people living with dementia to find their rooms and promoted their independence. Information on activities was displayed with pictorial aids to support people to understand activities available for them to take part in. Photos of staff were displayed in the dining room with their names attached to remind people of staff names and inform them who was on shift. The registered manager told us communal walls in the home were due to be painted different colours, to help people to understand where they were in the home. The registered manager had researched information on and provided suitable signage and environmental items of benefit for people with dementia in line with current guidance.

We recommend the provider makes further improvements to enhance the premises to meet people's needs.

Good

Is the service caring?

Our findings

Care staff knew people well and we observed them to be very caring. People told us that staff were kind "Overall". A person told us how they preferred certain members of staff although they were "All OK". A relative told us, "We are always made to feel very welcome every time we visit and our relative says that all the staff are very nice." A person told us how staff ensured their favourite toy "Had clean clothes on" as they washed its clothing regularly. Staff ensured the toy was placed within reach as they understood this was important to the person. Several people's beds had people's favourite toys sensitively displayed on them. Toys and dolls are used to improve the wellbeing of people living with dementia. A person told us, "I really feel the cold all the time even when it is hot and the staff know that. They always cover me." Staff had provided three blankets and had ensured the person was resting comfortably with their legs elevated. Staff said, "X has sore ankles, it is important to make sure they elevate their legs so they don't get swollen." Staff were kind and respectful when they served food for people and when they helped them eat. Staff took time to stop and talk to people. They knew people well using their knowledge of people to inform their conversations and created an atmosphere of wellbeing and homeliness. Staff ensured people were involved in conversations and activities and respected when people declined to join in.

During lunchtime a person had changed their mind about a meal option and had declined to have what they had previously chosen. The person asked what else was available and they were presented with two alternative options. The attitude of staff was respectful and the staff member ensured the person had a fresh cup of tea with their meal as their first cup had gone lukewarm. Staff were vigilant and regularly supplied people with drinks and gave people napkins to support their dignity. One person spilled their drink and staff attended to this quickly and calmly. People were supported by staff with eating and drinking when they needed encouragement. Staff were observed encouraging people by saying, "You've done well" and "Is that ok? Is it nice? Would you like some more?" They supported people's independence by asking someone, "Can I give you the spoon?" People who chose to, or who needed to for health reasons, were able to eat in their rooms. People told us they liked the food and staff attended to their needs.

We spent time in the communal areas and observed how people and staff interacted. The staff displayed a polite and respectful attitude. Staff provided care in a kind and sensitive way. They gave one person instructions in a calm and reassuring way. Staff thanked the person when they followed instructions to keep them safe. There was a friendly and appropriately humorous interaction between staff and people. During lunchtime staff crouched down to people's eye level to talk with them and encouraged people to eat. One staff member acted promptly when someone asked to be moved nearer the dining table to eat their meal. They checked that the person was more comfortable. Staff gave tissues to people who needed support to ensure their personal grooming needs were met whilst eating.

The registered manager had consulted with people's relatives to find out their views on the care service in October 2015. Comments read, 'X is treated very well', 'Staff are always very approachable. They always let me know if there are any problems', 'Staff are very caring. I have always been greeted warmly, pleasantly and with smiles' and 'Truly lovely staff, very helpful, I feel lucky for Mum to have them' and 'They never make you feel anything is too much.' One relative had written, 'Thank you for all your care in Mum's last few years.

I know they appreciated everything you did for them.' Another relative had written, 'With our thanks for the great kindness you have shown to X. Your carers are very special' and 'Thank you with all my heart for the loving and patient care you gave X. The care offered by and the staff far exceeded the standard one might expect. It made the move from their flat into a nursing home a smooth transition. One of the nicest aspects of care was the pleasure you all took from their sense of humour which they never lost and viewed their outbursts with understanding and compassion.' One relative wrote, 'Due to your patience and understanding their stay was very happy for them and us.'

The staff promoted independence and encouraged people to do as much as possible for themselves. People were encouraged to dress, wash and undress themselves when they were able to do so. Care plans gave clear information on people's independence levels. Recorded information included, 'Able to go to the toilet independently', 'Can mobilise around their room and from the lounge to their room with assistance of one staff member' and 'X is able to communicate their needs' and 'X can wash and dress independently.' One member of staff told us about their knowledge of people's independence levels. They said, "X is able to do their own personal care. I assist with areas they find difficult to reach. I encourage them to do armchair exercises to develop physical strength in their arms and legs. I encourage them to walk short distances.

People said they were treated with dignity and respect. Staff knocked before entering people's rooms. Doors were shut when people were receiving personal, intimate care. All care and ancillary staff interacted respectfully with people. We observed the environment in a shared room. One person was in their bed and the other person was in an armchair watching TV. There were curtains to provide a screen between the people when in bed receiving personal care. The registered manager told us they asked people whether they were happy to share rooms. For some people it benefitted their wellbeing to have the company of others. Staff told us about how they promoted one person's dignity. They told us how they gave someone a bowl of water to wash their face and areas they could reach. This supported and encouraged the person to maintain their personal care needs with dignity.

Advocacy services were available to people at the service. Advocacy services help people to access information and services; be involved in decisions about their lives; explore choices and options; defend and promote their rights and responsibilities and speak out about issues that matter to them. Staff ensured people were informed of their rights and supported people to access this service to make independent decisions about their care and support needs.

People's care plans contained either a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) or a statement reflecting the person's wishes to be resuscitated. However, one person's DNACPR had been completed prior to admission to the care home. This required updating to ensure the person's current wishes and needs were recorded. All of the care plans we reviewed had an advance care plan in place. Advance care planning is a process that enables individuals to make plans about their future care needs. Advance care plans provide direction to healthcare professionals when a person is not in a position to either make and / or communicate their own healthcare choices. Advance care plans are intended to lead to improvements in people's end of life care. The advance care plans provided general information, with the focus on resuscitation status and preferred place of care. The staff had a good rapport with relatives to support end of live planning to enable people to have choices at the end of their life.

We recommend the provider develops advance care planning to ensure people wider preferences and individual wishes are recorded about end of life care.

Requires Improvement

Is the service responsive?

Our findings

People told us, "The people are nice here, it feels like home even if it is not my home, but they try to make you happy", and "If I am not well they [staff] call the doctor" and, "The nurses are lovely, they understand how much I am in pain with and they watch out for me." One relative said they were "kept informed" about their loved one's care needs. We observed staff spending time with people. One staff member had a good knowledge of the person's family and background and used this to talk to the person about what interested them. They then moved on to talk with another person and spent time with them. However, one person told us, "There is nothing to do here in my room other than watch the TV."

Care plans reminded staff that the person's choices were important and staff were aware of people's preferences. For example, one person requested male carers only to support them and their preference was met. Staff were aware of people's history, preferences and individual needs and these were recorded in their care plans. For example one person's past profession was recorded along with their hobbies which included ballroom dancing. We observed staff referred to the person's passion for dancing whilst talking with them. Life story work is an activity which involves reviewing a person's past life events and developing a biography. Life Story Work enhances the care provided to older people particularly those living with dementia. Benefits include promoting individualised care, improving assessment, building relationships and improving communication, between people, their families and staff. Life story work was recorded in some people's care plans. However this was not consistently recorded within each person's care plans. Care plans contained specific details in a section called, "My little ways" which enabled care staff to personalise the care according to people's individual preferences. For example, one person liked to greet all their visitors in their room.

Care plans for people living with dementia included some guidance on how to encourage people and staff to communicate effectively with each other. An example of this was, 'I am able to communicate my needs, however, due to my dementia and poor hearing I am unable to hold a conversation and need people to speak slowly and clearly when talking to me and to allow me time to answer." We observed staff followed this guidance, ensured they talked clearly to people, gave clear instructions about how they were supporting people, reassured them and checked that they understood what was said. However, there was limited detail within the care plans about people's individual emotional and psychological needs and ways to meaningfully occupy the person using their life story and personal history. Staff talked with us about how they were supporting people with their individual goals which included improving their mobility, increasing their independence and pursuing individual hobbies and interests. However, there was no recorded information in people's care plans around goal setting or planning to support people to achieve their goals.

The registered manager had recently attended a 'virtual dementia tour' which had raised their awareness about the abilities and needs of people living with dementia. They planned to enable the staff team to have this experience. The virtual dementia tour provides staff with an opportunity to explore why people living with dementia are behaving the way they do and how to support them by reviewing care and developing care plans that reflect the individual needs of people living with dementia. They had started holding short discussions with staff about ways to support people living with dementia that recognised their expressions

and behaviours as a form of communicating unmet needs. The registered manager was planning further development with the care staff team to help them to better understand the experience of people living with dementia. This information was not yet fully reflected within people's care plans.

We recommend the provider continues to further develops people's care plans to record their individual needs, and staff then use this enhanced information to respond to those needs.

At the last inspection on 29 June 2015 there were insufficient meaningful activities available for people living with dementia. At this inspection we found that the registered manager had made improvements and that people were supported to take part in daily activities. There was an activities list on the wall which outlined activities people could get involved in. The list displayed pictorial prompts to support people to understand what activities were available. These included flower arranging, bulb planting, carpet bowls, reminiscence, tea and scones and 'tastes of the Orient' and local school children visits. There were photos on the walls in communal areas showing activities and outings people had taken part in. A photograph book and information on different local venues was in place to enable people to make choices about where to visit. People had attended various outings to include a trip to the local garden centre and a pub night. One person was very interested in knitting. There were knitting needles and wool available to them and others to pursue this hobby. One person had made a knitted bag and this was on display in the lounge area. One person was very interested in nature. Staff had ensured a bird table was installed outside their bedroom window so they could see the birds. They had nature books and magazines readily available to read in their room.

On the first day of our inspection a hairdresser was visiting and people enjoyed having their nails painted. On the second day of our inspection someone was celebrating their birthday. A singer and entertainer had been booked. They came to perform old time songs to people in the afternoon. We observed people clapping and tapping in time to the music. The registered manager showed us a schedule for the year where they had made bookings for the entertainer and a 'Pat the dog' person and their dog to visit the home. Other activities included gentle exercise to music, jigsaws, skittles, soft ball games, crosswords and reminiscence work. A reminiscence area had been set up in one corner of the home where people could sit and look at memorabilia and reminisce about the past. This supported people, particularly those living with dementia to recall memories and stimulate social interaction with other people.

An activities co-ordinator was employed five days per week. They told us, "I love being with people here. I have got to know them. People have individual activities. For example one person loves to do colouring. Another person loves music and dancing. Another person likes to have conversations with me about current affairs. One person simply likes to grip my hand for comfort. I do reminiscence work with people. For example one person brought some photographs of their family and we made a photo album. Some people like to do exercise and flower arranging. We have music sessions. People tend to relate to music from the 1960's." Each person had an individual activities file. The activities co-ordinator completed daily records to demonstrate when and how often people engaged in activities. These records were called 'activity participation records.' For example one person liked to have a hand and foot massage. Another person had knitted some fingerless gloves with support. One person's hobby was book binding. The activities co-ordinator obtained materials for them to bind a book which they were working on. Records showed that staff checked on people who stayed in their bedrooms during the day and provided information on any meaningful engagement staff had with them. For example one person had an active interest in the Royal family. It was recorded that they discussed a newspaper article about the Queen. Other records read, 'Visited X in their room had a good conversation' and 'X enjoyed a hand and foot massage' and 'We played bingo' and 'X had a good time. They participated in flower arranging.' The registered manager told us they would continue to review activities with people to meet their individual needs.

People's bedrooms reflected their personality, preference and taste. For example, people's rooms contained personal furniture and belongings and people were able to choose furnishings and bedding. One person had recently chosen the colour scheme for their bedroom. Private areas were created for people who shared a bedroom. One person was particularly fond of cats and staff had displayed multiple images of cats around their bed. People had choice about when to get up and go to bed, what to wear, what to eat and what to do. One person wanted to have a lie in each morning and staff changed the staff shift handover time to meet the person's preference and request.

The registered manager told us about one person who had difficulties walking. The person's aim was to improve their mobility and independence. Staff supported them to practice walking short distances and to carry out small personal care tasks independently. With encouragement and consistent support from staff the person was continuing to improve their mobility. A second person previously came to the home and needed support to develop their skills and confidence when walking. Within a short timeframe their mobility improved to the point where they were able to return home in line with their preferences. It was recorded in their care plan, 'Much better mobility. Very confident in walking' and 'X is enjoying the freedom of increased mobility.' One person's journey from a relative's perspective was reported in a local newspaper which read, 'Within 24 hours of arrival [at the home] X was dressed and walking with a Zimmer frame after five bedridden weeks in hospital.' One relative had written, "I am most grateful that you have given me hope that X will cope with a walking frame in the future at home." Staff told us how they encouraged someone to improve their walking skills. They said, "When they came to us they were in a wheelchair [because of a health need]. We support X to walk for short periods. They like to practice walking from their bedroom to the lounge. They had exercises to do and we encourage them to do these."

Staff told us about one person they supported who was living with dementia and how they met their needs and preferences. They had attended training in dementia awareness. They explained to us how they helped keep the person calm and reduced their anxiety levels. They said, "When I am supporting X with personal care, I talk to them about their family. This helps to reassure them and keep them feeling safe. Sometimes they don't remember who I am. I mention names of people in their family and that helps them to relax and remember who I am. I explain to them what I am doing. I know the activities they like to do. They like colouring and having their nails polished. They used to be a dancer, so sometimes we look at photo albums of when they used to be a dancer." During the second day of the inspection staff were supporting the person to dance when an entertainer was present at the home. The person was very happy and was beaming with joy. Staff talked to them about when they used to be a dancer and they appeared very engaged in the activity.

People said they could have visitors at any time of the day and all visitors were made to feel welcome. People were encouraged and supported to develop and maintain relationships with people that mattered to them. Relatives were visiting people during our inspection. One record in a person's care file read, 'X spent time with their son today.' One relative wrote, "X's 100th birthday party was a memorable occasion, enjoyed very much by X and family. You cannot put a price on the effort that was made on that day and every day during their stay." Another relative wrote, "Thank you to you and your staff for making mum's 90th birthday an enjoyable occasion. [Thank you for] the hospitality shown to us by your staff making all the teas and coffees and making our visit family orientated. We as a family [took] some lovely pictures of mum and a video of us all singing happy birthday whilst out the candles, which we will all treasure. Thank you so much for the beautiful birthday cake which was absolutely delicious."

People attended resident meetings to discuss aspects of the service and give feedback about how the service should be run. People made requests about food they would like on the menu. For example several people requested spicy foods and curries were made available. The cook ensured people's preferences were

included on the menu. People made requests about activities and social outings they wanted to take part in. The registered manager had introduced an activities planner and a range of alternative activities for people to take part in response to the wishes and preferences.

The registered manager sent surveys to people and their relatives so they could give feedback to develop the service. The last relative's survey was completed in October 2015. The positive feedback from relatives had been recorded. One relative had responded that they would like to be more involved in the care provided to their loved one. The registered manager responded by contacting the relative and had arranged to meet with them on a regular basis in response to this feedback. Another relative had commented, 'There is a long wait when telephoning the home.' In response to this the registered manager ensured the nurse in charge carried a mobile phone with them throughout the day to respond to calls more promptly.

The complaints policy was available to support people to understand how to make a complaint. The registered manager showed us the complaints procedure. People were provided with a brochure about the service when they came to live there and there were posters available to explain to people how to make a complaint. One complaint had been recorded since our last inspection. We saw that where complaints had been received, the registered manager had responded appropriately.

Requires Improvement

Is the service well-led?

Our findings

There was an open and positive culture which focussed on people. The registered manager explained how they were holding small meetings with the care team to share ideas and encourage more person centred practice. Care staff were warm in their approach and there appeared to be an open culture of care. People we spoke with knew of the registered manager who was visible in the home. They said, "She is around a lot, we can always talk to her, she is nice" and, "She cheers me up." They told us they would speak to staff or the registered manager if they had cause to complain. Relatives told us, "The manager is always very welcoming, she is very dynamic, quite approachable; we wouldn't hesitate to contact her if we had any problems." The staff we spoke with were positive about the support they received from the registered manager. One staff member said, "It is good here. The staff are nice and it is a good team. We communicate with each other." Another staff member told us, "The management is ok. They listen to me."

The registered manager completed medicines audits every two months. The provider's pharmacy had completed a medicines audit on 28 February 2016. They had made recommendations that the provider ordered medicines earlier to reduce the risk of shortages occurring. The registered manager had actioned this recommendation. However, improvements were needed to ensure people received PRN and topical medicines as required. The provider's internal medicines audit had not identified the need for improvements in medicines management that we identified at this inspection.

The registered manager completed monthly audits of people's care files to check records such as care plans and risk assessments were accurate, reviewed, updated appropriately and fit for purpose. Although staff had recorded monthly evaluation notes, in some care plans the care described did not consistently reflect people's current assessed care needs. The provider's internal care plan audit had not identified the need for improvements we identified at this inspection.

Since our last inspection on 29 June 2015, the registered manager had made improvements to develop quality assurance and governance systems at the service. They had sought and provided additional training to staff about MCA and DoLS and maintained clear records to evidence the action taken in regard to MCA and DoLS. They had developed cleaning schedules to ensure essential infection control measures were maintained and had oversight of this. One professional told us, "I have been working really closely with the registered manager regarding improving the service after CQC's last visit. [The registered manager] has taken on board a lot of my recommendations to improve the auditing side of managing the service. I visited the service at the beginning of this year and found the paperwork to be in much better order and that the registered manager was very engaged with us in terms of advice to improve certain aspects."

The registered manager completed regular accident and incident audits. They analysed patterns and trends and put in place control measures in response to concerns identified. For example, one person had experienced three falls. The registered manager reviewed the person's care plan, ensured their medicines were reviewed and put in place a sensor mat to alert staff should the person attempt to mobilise unaided to reduce the risk of future falls.

The registered manager had in place a catering audit. This included a daily kitchen cleaning schedule. People were consulted by means of a 'catering satisfaction survey' in March 2016. No negative feedback was recorded. Comments read, 'Sometimes I like to have meals in my room', Meals taste very good', 'All meals are very nice' and 'No concerns about food here.' The service held a current Food and Hygiene Certificate at the highest possible rating level of 5. We saw the kitchen was clean and well maintained.

The registered manager had completed night shift audits to ensure essential care standards were being met by night staff. These audits were completed on an unannounced basis to spot check that staff provided care to people appropriately. Three night audits had been completed since August 2015. No issues had been identified as part of this audit.

A maintenance audit was completed every two months. Actions had been addressed that had been identified as part of this audit. For example the door was replaced to the lift by the near lounge. A maintenance audit was in place to demonstrate which maintenance issues had been addressed and whether any maintenance issues were outstanding.

There was a refurbishment plan in place from March 2016 to April 2017. The dining room and lounge walls had been painted and the furniture varnished in April 2016. Other areas were due to be refurbished to include the outside of the building. A sensory room was to be set up by 31 July 2016. The carpets in the lounge and landing were also due to be replaced.

The registered manager completed a dignity and privacy audit. They walked around the home and spot checked staff providing care and support to people. They recorded observations such as, 'Staff knock on people's doors', 'People in transit to the bathroom were suitably covered, and staff completed relevant training.' This ensured that people's privacy and dignity needs were being monitored.

The culture of the home was welcoming and the staff were focused on the people they care for and there was a sense that staff cared for and respected people. From the way the registered manager described their role and their vision for the home they showed they were passionate about providing care to people in a compassionate and caring way. They had communicated this vision to the staff because staff made comments including: "I want people to feel like this is home from home and that people feel happy in themselves. I want people to be able to express their wishes, needs and feelings and be happy, comfortable and safe." One staff member said, "I want people to feel safe, have their dignity respected, be comfortable and have good food." The staff took action to make sure the philosophy of care was promoted in practice.

The registered manager had completed leadership training in dementia care with Surrey and Borders Partnership – NHS Foundation Trust. This provided them with information and learning materials on best practice in dementia care. The registered manager told us about ideas they had to develop meaningful activities for people living with dementia. Some of these ideas had been started while others were yet to be implemented in practice. The registered manager had kept informed with latest development in the delivery of health and social care in order to improve their service. One professional wrote, '[The registered manager] is coming along to dementia workshops and is also heavily involved in local provider forums.'

Staff team meetings were held regularly to discuss the running of the service. Records of these meetings showed that staff were reminded of particular tasks and of the standards of practice they were expected to uphold. One member of staff told us about how their suggestions helped influence service improvements at the home. They told us how they had suggested people might like to see old war time advertisements and memorabilia to help people recall their personal memories from the past and encourage people to socially interact with each other. In response to this a reminiscence area was set up in a corner of the home and

people took part in activities around this.

The registered manager notified the Care Quality Commission of any significant events that affected people or the service. Records indicated the registered manager took part in safeguarding meetings with the local authority when appropriate to discuss how to keep people safe, and kept people's families involved in decisions concerning their family members' safety and welfare.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2. (c) Without limiting paragraph (1), such systems or processes had not enable the registered person to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.