Bupa Care Homes (CFC Homes) Limited

Dean Wood Nursing and Residential 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**

Overall summary

We inspected Dean Wood Nursing and Residential Care Home on the 24 and 25 February 2015. Dean Wood Nursing and Residential Care Home provides care and support to people with personal care and nursing needs, many of whom were living with dementia.

The home is arranged over three floors, offering residential and nursing care based on people's particular needs and requirements. One area is a specifically designed unit which provides an environment that supports people living with dementia. The environment was dementia friendly and assisted people with orientation around the home. The home can provide care and support for up to 80 people. There were 76 people living at the home on the days of our inspections.

Dean Wood Nursing and Residential Care Home belongs to a large corporate organisation called BUPA. BUPA provide residential and nursing care across England.

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

Summary of findings

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.

Dean Wood Nursing and Residential Care Home was last inspected on 9 January 2014 and no concerns were identified. However, at this inspection we found areas of improvement required in respect to moving and handling practices, the management of medicines, staff supervision meetings and the culture of the service in relation to staff satisfaction.

Despite staff receiving appropriate training in the moving and handling of people, we saw unsafe moving and handling practices taking place which placed people at risk of harm. We have identified this as an area of practice that requires improvement.

Medicines were stored appropriately, but documentation used to show people had received their medicine contained errors and omissions. We have identified this as an area of practice that requires improvement.

Staff had formal personal development plans, which included regular supervision meetings with their manager. However, these one to one meetings had not routinely been taking place. We have identified this as an area of practice that requires improvement.

The culture and values of the provider were not embedded into every day care practice. Staff we spoke with did not have a strong understanding of the vision of the home. Although some staff spoke positively of the culture and how they all worked together as a team, feedback from other staff was mixed and indicated that there was a lack of cohesion and a negative culture in the home. We have identified this as an area of practice that requires improvement.

People were happy and relaxed with staff. They said they felt safe and there were sufficient staff to support them. When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work with adults at risk. Staff were knowledgeable and had received training on safeguarding adults. Staff understood what action they should take if they suspected abuse was taking place.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that staff understood the principles of DoLS, when an application should be made and how to submit one.

Where people lacked the mental capacity to make a specific decision the home was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests.

Accidents and incidents were recorded appropriately and steps taken by the service to minimise the risk of similar events happening. Risks associated with the environment and equipment had been identified and managed.

People were encouraged and supported to eat and drink well. One relative said, "My mother has eaten more in the few days she has been here than in her last residential home". There was a varied choice of meals and people were able to give feedback and have choice in what they ate and drank. People were advised on healthy eating and special dietary requirements were met. People's weight was monitored, with their permission. Health care was accessible for people and appointments were made for regular check-ups as needed.

People could choose how to spend their day and they took part in activities in the home and the community. People told us they enjoyed the activities, which included coffee mornings, singing, exercises, films, bingo, quizzes and a social club.

Staff had received essential training and there were opportunities for additional training specific to the needs of people. Care plans gave information on how people wished to be supported and daily records showed what care had been delivered.

People felt well looked after and supported. We observed friendly and genuine relationships had developed between people and staff. One person told us, "I trust them and they know what they are doing". A relative said, "I'm confident my relative is being well cared for". Care plans described people's needs and preferences and they were encouraged to be as independent as possible.

People were encouraged to stay in touch with their families and receive visitors. Relatives were asked for their views about the service and the care delivered to their family members. Completed surveys showed families

Summary of findings

were happy overall and felt staff were friendly, welcoming and approachable. Residents' and relatives meetings were held and people said they felt listened to and any concerns or issues they raised were addressed.

People were involved in the development of the service and were encouraged to express their views. The provider undertook quality assurance reviews to measure and monitor the standard of the service.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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.

Despite staff receiving appropriate relevant manual handling training, unsafe moving and handling techniques were seen.

Medicines were stored appropriately, but documentation reflected errors and omissions in the recording of medicine administration.

Staff were trained in how to protect people from abuse and knew what to do if they suspected it had taken place. Staffing numbers were sufficient to ensure people received a safe level of care. People told us they felt safe. Recruitment records demonstrated there were systems in place to ensure staff were suitable to work with adults at risk.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service had formal systems of personal development, such as supervision meetings, but these had not routinely been taking place.

Staff received training which was appropriate to their job role. This was continually updated, so staff had the knowledge to effectively meet people's needs.

Staff had a good understanding of peoples care and mental health needs. Staff had received essential training on the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and demonstrated a sound understanding of the legal requirements.

People were able to make decisions about what they wanted to eat and drink and were supported to stay healthy. They had access to health care professionals for regular check-ups as needed.

Is the service caring?

Good

The service was caring.

People felt well cared for and were treated with dignity and respect by kind and friendly staff. They were encouraged to increase their independence and to make decisions about their care.

Staff knew the care and support needs of people well and took an interest in people and their families to provide individual personal care.

Care records were maintained safely and people's information kept confidentially.

Summary of findings

Is the service responsive?

Good

The service was responsive.

People were supported to take part in a range of recreational activities both in the home and the community. These were organised in line with peoples' preferences. Family members and friends continued to play an important role and people spent time with them.

People and their relatives were asked for their views about the service through questionnaires and surveys. Comments and compliments were monitored and complaints acted upon in a timely manner.

Care plans were in place to ensure people received care which was personalised to meet their needs, wishes and aspirations.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Staff felt that on the whole they were supported by management, were listened to, and understood what was expected of them. However, some staff feedback indicated dissatisfaction with working at the service, and a negative culture.

People were able to comment on and be involved with the service provided to influence service delivery.

Systems were in place to ensure accidents and incidents were reported and acted upon. Quality assurance was measured and monitored to help improve standards of service delivery.

Dean Wood Nursing and Residential 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 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.

The inspection took place on the 24 and 25 February 2015. This visit was unannounced, which meant the provider and staff did not know we were coming.

Three inspectors and an expert by experience in older people's care undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the Local Authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. Before the inspection we spoke with the Local Authority and Clinical Commissioning Group (CCG) to ask them about their experiences of the service provided to people.

We observed care in the communal areas and over the three floors of the home. We spoke with people and staff, and observed how people were supported during their lunch. We spent time looking at records, including four people's care records, five staff files and other records relating to the management of the home, such as complaints and accident / incident recording and audit documentation.

We looked at areas of the building, including people's bedrooms, the kitchens, bathrooms, and communal lounge. Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. During our inspection, we spoke with 13 people living at the home, two visiting relatives, six care staff, the chef, the receptionist, an activities co-ordinator, two registered nurses, the registered manager and the regional manager.

Requires Improvement

Is the service safe?

Our findings

People and their relatives said they felt safe and staff made them feel comfortable. One person told us, “Yes I feel safe here”. Although people told us they felt safe, we found areas of practice which were not consistently safe.

We observed staff delivering care in the communal area on the ground floor, where people and staff were watching a singer. At 15:49pm we witnessed two staff members move a person from a wheelchair to an armchair by means of using a 'drag' lift. The 'drag' lift is any method of handling where the carer(s) places a hand or arm under the person's armpit. Use of this lift can result to damage of the spine, shoulders, wrist and knees. For the person lifted, there is the potential of injury to the shoulder and soft tissues around the armpit. Risk of fractures to the bone of the upper arm (humerus) and dislocation of the shoulder is also a possibility. The Royal College of Nursing provided the following guidance about the use of this lift technique 'Unless there is an emergency (needing immediate action to avoid serious harm to a patient's health) drag lifts must not be carried out'. (Guide to the handling of patients' (RCN and NBPA 1997, 4th edition). We addressed this with the nurse on duty in this area, the registered manager and the regional manager. It was established that both staff members had received appropriate and relevant training around moving and handling. However, this demonstrated that this training had not been embedded into practice. The provider had not ensured that people were protected from receiving care that was unsafe or inappropriate. The details of this incident have been raised with the Local Safeguarding Authority.

The above is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have identified this as an area of practice that requires improvement.

We looked at the management of medicines. The registered nurses were trained in the administration of medicines, as were some care staff. A registered nurse described how they completed the medication administration records (MAR). MAR charts are the formal record of administration of medicine within a care setting. We saw several MAR’s contained omissions or had not been filled out correctly. For example, one person required a drug to assist with incontinence. We saw that on the 23 February 2015 their MAR chart was signed that this drug had been given to them. However, it was still in its blister pack for this day and had not been administered. Another person required a drug to treat hypertension. Their MAR chart also showed that on the 23 February 2015 their tablet had been given to them. However, it was still in its blister pack for this day and had not been administered. A further person’s MAR chart was signed to show their Aspirin had been administered to them on the 12 February 2015, however this tablet was still in its blister pack. One person’s MAR contained gaps in the recording of administered medication on both the 10 February 2015 and the 16 February 2015. There was no information recorded to explain whether the medication had been given, or the reasons why it hadn’t.

Inaccurate medicine recording places people at risk as they may not get the medicines they need, which may be vital to their health and wellbeing. Alternatively, staff may give the wrong medicine in error if there are gaps or errors in the information. Clear records help to prevent drug errors. Everyone involved in looking after medicines for other people is responsible for keeping good records. We have identified this as an area of practice that requires improvement.

Despite the above concerns, people told us they received their medicines on time. One person told us, “They give me my medicine when I need it”. We observed staff administering medicines to people. Staff were polite and made sure that people were comfortable and ready, and told people what they were taking.

Medicines were stored appropriately and securely and in line with legal requirements. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of appropriately.

Staff described different types of abuse and what action they would take if they suspected abuse had taken place. There were a number of policies to ensure staff had guidance about how to respect people’s rights and keep them safe from harm. These included clear systems on protecting people from abuse. One member of staff told us, “I would not hesitate to report anything that I saw”. Records confirmed staff had received safeguarding training as part of their essential training at induction and that this was refreshed regularly.

Requires Improvement

Is the service safe?

There were systems to identify risks and protect people from harm. Each person's care plan had a number of risk assessments which were specific to their needs. The assessments outlined the benefits of the activity, the associated hazards and what measures could be taken to reduce or eliminate the risk. We spoke with the registered manager about the need to balance minimising risk for people and ensuring they were enabled to try new experiences. They said, "We meet with people and their families prior to their admission. This is the starting point for their care plan. We speak to their GP and look at their mobility and discuss their requirements and what they want to do. We then check after 72 hours to make sure the care plan we have is appropriate". In relation to explaining risks to people and assisting with their independence, the registered manager added, "Communication with people and their families' is key, using the right language. We explain the situations, for example that smokers can't smoke in their rooms, but we will support people to smoke elsewhere. We work with them to reach a compromise that suits them, but minimises the risk".

Staff were knowledgeable about the people they supported and specifically how to support people with behaviour which might challenge. Staff demonstrated they understood how to respond to people's behaviour and recognised the triggers which could cause a person to become challenging. One staff member told us, "We have a resident that can sometimes intimidate others. We will use distraction techniques to intervene".

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff and people knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of electrics, moving and handling equipment, food hygiene, hazardous substances, staff safety and welfare. There was a business continuity plan. This instructed staff on what to in the event of the service not being able to function normally, such as a loss of power or evacuation of the property.

Staffing levels were assessed to ensure people's safety. The registered manager told us, "We have enough staff. We use the 'staffing ladder' which determines the number of hours of care we need. The pre-assessment information determines the hour's people need and this allows us to determine the number of staff we need to deliver it. We can add more staff as needed, for example we put on an extra nurse when the GP does their round". They added "We liaise regularly with staff and relatives about staffing levels and we don't take people into the home that we could not manage. We have bank staff [Bank staff are employees who are used on an 'as and when needed' basis] and have incentives for staff to cover shifts at short notice. We can also use agency staff". Feedback from people indicated they felt the service had enough staff and our own observations supported this. In respect to staffing levels and recruitment, the registered manager added, "We have ongoing recruitment for care staff. At interview we give a lot of details about what the job is like and manage their expectations, so that they know what they are getting into. We take them around the home to see how they interact with people. We hire for attitude and we train for skills". Documentation we saw in staff files supported this, and helped demonstrate that staff had the right level of skill, experience and knowledge to meet people's individual needs.

Records showed staff were recruited in line with safe practice. For example, employment histories had been checked, suitable references obtained and appropriate checks undertaken to ensure that potential staff were safe to work within the care sector.

Requires Improvement

Is the service effective?

Our findings

People told us they received effective care and their needs were met. One person told us, "I trust them and they know what they are doing". However, we found areas of practice which were not effective.

Staff received support and professional development to assist them to develop in their roles, and feedback from the registered manager confirmed that formal systems of staff development, including supervision meetings and annual appraisal were in place. Supervision is a system to ensure that staff have the necessary support and opportunity to discuss any issues or concerns they may have. However, we were informed by the registered manager that regular formal supervision sessions had fallen behind and had not consistently taken place for care staff. Care staff we spoke with appeared vague about when they had last received supervision or when their next one was due. The registered manager and regional manager were aware of the situation and had formulated an action plan to prioritise that one to one supervision sessions were brought up to date.

Regular and good supervision is associated with job satisfaction, commitment to the organisation and staff retention. Supervision is significantly linked to employees' perceptions of the support they receive from the organisation and is correlated with perceived worker effectiveness. The emotionally charged nature of care work can place particular demands on people in the field. It is therefore important to provide regular opportunities for reflective supervision. We have identified the above as an area of practice that requires improvement.

Staff had received training that was specific to the needs of people, for example in food hygiene, fire evacuation, health and safety and equality and diversity. Staff completed an induction when they started working at the service and 'shadowed' experience members of staff until they were deemed competent to work unsupervised. They also received training which enabled them to provide effective care, for example around the care of people with dementia, and with managing pressure care. Specialist trainers such as tissue viability nurses (TVN) and dementia specialist nurses also carried out training for staff at the home. One member of staff told us, "I have completed all my mandatory training and medication training and have been observed and signed off by my team leader. Staff get support from a trainer that comes to the home to do in-house training. I don't struggle to attend any training sessions".

Staff told us they explained the person's care to them and gained consent before carrying out care. Staff we spoke with understood the principles of the Mental Capacity Act 2005 (MCA) and gave us examples of how they would follow appropriate procedures in practice. The MCA is a law that protects and supports people who do not have the ability to make decisions for themselves. There were also procedures in place to access professional assistance, should an assessment of capacity be required. Staff were aware any decisions made for people who lacked capacity had to be in their best interests.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The provider was meeting the requirements of DoLS. The registered manager understood the principles of DoLS, and knew how to make an application for consideration to deprive a person of their liberty. Three decisions to deprive somebody of their liberty were in place, and the home was consulting with the Local Authority to keep these people safe from being restricted unlawfully.

People had an initial nutritional assessment completed on admission. Their dietary needs and preferences were recorded. The chef told us, "We can provide anything anyone could ask for. Special diets and cultural food can be catered for". People's weight was regularly monitored, with their permission. Some people were provided with a specialist diet to support them to manage health conditions, such as swallowing difficulties. The registered manager said, "People are assessed for their diet when they arrive. We have people who are vegan or diabetic, or need finger food, so we have regular contact with dieticians and speech and language therapists (SALT). Each person has their likes and dislikes recorded and we liaise with residents and relatives regularly about food". The staff we spoke with understood people's dietary requirements and how to support them to stay healthy.

We observed lunch. It was relaxed and people were considerately supported to move to the dining areas, or could choose to eat in their bedroom. People were

encouraged to be independent throughout the meal and staff were available if people wanted support, extra food or drinks. People ate at their own pace and some stayed at the tables and talked with others, enjoying the company and conversation.

The menu was displayed for people and showed the options available that day. People also told us the staff asked them what they wanted to choose each day. Everybody we asked was aware of the menu choices available. The staff knew individual likes and preferences and offered alternatives. People were on the whole complimentary about the meals served. One person told us, “I can order whatever I want and they will cook it. Now the food is slightly more to my taste. I have just had a savoury pancake which was good”. A relative said, “My mother has eaten more in the few days she has been here than when she was in her last care home. The food is soft and she can swallow it". We saw people were offered drinks and snacks throughout the day. People told us they could have a drink at any time and staff always made them a drink on request.

Care records showed when there had been a need; referrals had been made to appropriate health professionals. The registered manager told us, “Staff would recognise when people got poorly and they wold make sure that they got the nurses to check on them”. We saw that if people needed to visit a health professional, such as a dentist or an optician, then a member of staff would support them. The registered manager added, “We explain to the residents about any conditions they have or procedures that need doing. For example, one resident needed their ears syringed, we spoke with them and their family and explained the procedure and what was involved, and showed them the equipment that was used. They decided that they did not want it done, it was their choice”.

Good

Is the service caring?

Our findings

People were supported with kindness and compassion. People told us caring relationships had developed with staff who supported them. Everyone we spoke with thought they were well cared for and treated with respect and dignity, and had their independence promoted. A relative told us, "I'm confident my relative is being well cared for".

Interactions between people and staff were positive and respectful. There was sociable conversation taking place and staff spoke to people in a friendly and respectful manner, responding promptly to any requests for assistance. One relative told us, "She smiles now, but did not smile in the last residential care home". Another relative said, "All my family are happy with the care my relative gets in this home".

Staff relationships with people were supportive and caring. Staff demonstrated a strong commitment to providing compassionate care. From talking to staff, they each had a firm understanding of each person's likes, dislikes, personality, background and how best to provide support. One staff member told us about a person who had limited communication, they said, "She cannot always tell you what she wants, like if she is in pain, but we can tell now through her facial expressions, as we know her well". The registered manager said, "We care and this filters down to all the staff. We have a good knowledge of all the residents, they are not just bed number 59, they are a person".

The atmosphere in the home was calm and relaxed, but there was also a general hum of activity. A safe, well designed and caring living space is a key part of providing dementia friendly care. A dementia friendly environment can help people be as independent as possible for as long as possible. It can also help to make up for impaired memory, learning and reasoning skills. People's bedrooms had pictures of how they recognised themselves to help orient them and walk around the home independently. Considerable thought had been used when designing the environment to promote people's wellbeing. The communal lounges and dining areas provided a comfortable environment, with dining tables, armchairs, televisions, reading material and articles of interest.

People looked comfortable and they were supported to maintain their personal and physical appearance, and were dressed in the clothes they preferred and in the way they wanted. A hairdresser visited the home on a regular basis and on the day of the inspection, a person informed us that he was off downstairs to get a haircut.

People told us that staff were caring and respected their privacy and dignity. Staff had a clear understanding of the principles of privacy and dignity and had received relevant training. During the inspection, staff were respectful when talking with people calling them by their preferred names. We observed staff knocking on people's doors and waiting before entering. Staff were also observed speaking with people discretely about their care needs. Care records were stored securely, information was kept confidentially and there were policies and procedures to protect people's confidentiality.

People were consulted with and encouraged to make decisions about their care. They also told us they felt listened to. A relative told us that their loved one now required nursing care. However, when they were admitted to the home it was within the residential unit. The relative and their loved one wished to stay on the residential unit, as this is where they felt most comfortable. The home had agreed to this, to provide continuity of care and when nursing care was required, a nurse from another area of the home would support them in the residential unit. Staff supported people and encouraged them, where they were able, to be as independent as possible. A staff member told us about a person who often refused to be washed and assisted to dress. They said, "We encourage him to do as much as he can for himself, and support him if he needs us to".

People's care plans contained personal information, which recorded details about them and their life. This information had been drawn together by the person, their family and staff. Staff told us they knew people well and had a good understanding of their preferences and personal histories. For example, one person's care plan explained how they became anxious when they were left alone. They stated that they wished to be in the company of other people as much as possible, and we saw that this had happened. The registered manager told us, "We have involvement with family and we put people's life histories in place. We develop personal care plans". People we spoke with confirmed that they had been involved with developing their or their relative's care plans.

Good

Is the service caring?

Meetings were held regularly for people at which they could discuss things that mattered to them and people said they felt listened to. Meeting minutes showed that people and their relatives had discussed staff turnover, activities and general feedback about the home. A service user and relatives' satisfaction survey had been sent out in September/October 2014, however the results of which were still in the process of being analysed. A previous survey was completed in January 2014, showing that people were overall satisfied with the service.

Visitors were welcomed throughout our visit. Relatives told us they could visit at any time and they were always made to feel welcome. The registered manager told us, "There are no restrictions around visiting. Relatives can stay over, for example if somebody is at the end of their life. Relatives can stay for lunch and hire rooms for parties. A family organised a surprise party for their relative here and booked a room. We also offer a fine dining restaurant service". A visitor said, "I'm always offered lunch and we have a code to get in the front door if it is out of hours, we just have to sign in".

Good

Is the service responsive?

Our findings

People told us they were listened to and the service responded to their needs and concerns.

There was regular involvement in activities and the service employed three activity co-ordinators. Keeping occupied and stimulated can improve the quality of life for a person, including those living with dementia. Activities were organised in line with people's personal preferences, for example several people had formed a social club at the home and met regularly, and several people had attended local church services. We also saw a varied range of activities on offer, which included coffee mornings, singing, exercises, films, knitting, bingo, quizzes and a social club. On both days of the inspection, we saw activities taking place for people. We saw people playing bingo and staff supported people to check their numbers. We also saw a singer entertaining people in one of the communal lounges. People appeared to thoroughly enjoy the stimulation and the activities enabled people to spark conversations with one another. The activities co-ordinator's recorded the activities that people attended and gained their feedback, to assist with planning future activities that were relevant and popular.

The home supported people to maintain their hobbies and interests, for example one person regularly had lunch at a local restaurant and enjoyed playing bridge in the local town. They were supported to do this by a member of staff they got on well with. Another person liked animals and had a dog live with them at the home. The registered manager told us, "We have two people living here who were in the original Chitty Chitty Bang Bang, so we know they have an interest in musical theatre, which we encourage". The home also encouraged people to maintain relationships with their friends and families. One person told us that the home was fitting a charging point on the corridor, so they could use their new electric scooter, they said, "I shall be able to come and go as I please, and I am looking forward to making friends in and out of Dean Wood".

Care plans demonstrated that people's needs were assessed and plans of care were developed to meet those needs. Visiting relatives confirmed they were involved in the formation of the initial care plans and were subsequently asked if they would like to be involved in any care plan reviews. Relatives commented they felt happy in being able to contribute to their loved ones care plan.

Care plans showed people's preferences and histories. The staff demonstrated a good awareness of people and also how living with dementia could affect people's wellbeing. The individualised approach to people's needs meant that staff provided flexible and responsive care, recognising that people, including those living with dementia could still live a happy and active life. Care plans incorporated information about people's past's, hobbies, activities and their personality traits which enabled staff to provide person centred care and engage with people about their history. The registered manager gave us an example of a person who liked to move boxes around, as they used to work in a warehouse. They provided cardboard boxes and the person happily moved them around. The registered manager added, "We had a resident who used to isolate themselves. We found out that they liked animals, so some of the staff bought their pets in for them. This has increased their confidence and they now come out to the nurse's station and sit and have a chat".

Each section of the care plan was relevant to the person and their needs. Areas covered included mobility, nutrition, daily life, emotional support, continence and personal care. Information was also clearly documented on people's healthcare needs and the support required managing and maintaining those needs. A profile was available which included an overview of the person's needs, how best to the support the person and what is important to that individual. Care plans contained detailed information on the person's likes, dislikes and daily routine with clear guidance for staff on how best to support that individual. For example, one person specifically liked a cooked breakfast and white tea with two sugars. Another person wished to start getting settled for bed at around 7:30pm, but wished to be given the choice as to what time they actually went to bed. Equally, care plans recorded when people did not wish to discuss their life history, or talk about their interests or preferences.

Records showed comments, compliments and complaints were monitored and acted upon. Complaints had been handled and responded to appropriately and any changes and learning recorded. For example, the registered manager showed us a report on daily staffing numbers that

Good

Is the service responsive?

was produced in light of a complaint. Staff told us they would support people to complain. The procedure for raising and investigating complaints was available for people. One person told us they were not happy with the way a member of staff had spoken with them. They said, "I reported it to the unit manager and it was dealt with. They arranged for them to have more training". Another person said, "They absorb what we say about complaints and act on it". We saw that feedback from complaints was analysed monthly, in order to identify any trends and to improve the service delivered.

Requires Improvement

Is the service well-led?

Our findings

Comments we received from people and staff indicated they felt the home was well led. However, we found areas of practice which required improvement.

We discussed the culture and ethos of the service with the registered manager. They told us, "The culture starts at the top, with 'Bigger BUPA' and having 20:20 vision of the service. We get to know the residents, their relatives and they are part of the whole. For example, the relatives will know the housekeepers names, it breaks the barriers between 'you' and 'I'". In respect to staff, the registered manager added, "We encourage staff to come to us with issues or mistakes, we want to listen and be transparent. We also recognise where we haven't got it right". We were shown an example whereby as a result of from feedback from staff, that changes to the staffing rota had been made to accommodate an extra care worker on shift, rather than a hostess worker.

However, we found that the culture and values of the provider were not embedded into every day care practice. Feedback from staff was not always positive about the culture of the home. Staff we spoke with did not have a strong understanding of the vision of the home. Although some staff spoke positively of the culture and how they all worked together as a team, feedback from other staff was mixed and indicated that there was a lack of cohesion and a negative culture in the home. One staff member told us, "There is a lot of playground arguing and not working as one here. It's three separate units". Another member of staff said, "BUPA are the worst people I've ever worked for, morale is really low, they are too controlling. I've witnessed staff criticising each other off in front of the residents and their families. We get on and respect that we are in the residents' home, but there is no management support, no help and we're not listened to". A further member of staff added, "I can't work for a company that doesn't care about the residents".

We received further negative comments from staff around the day to day conduct and interactions between staff. One member of staff said, "We're really busy and the nurses rarely help out on the floor. At handover we get information about people's changing needs, but often get conflicting information from nurses". Another told us, "We've raised issues about other staff at staff meetings, but they don't get written down". A further member of staff told us, "No support from the nurses". Additionally we were told, "It feels like all the staff should just get together and have it out and try and iron out the problems, between nurses, carers and activities staff. I've raised things with other staff, but I just got shouted down".

We raised these concerns with the registered manager, who told us, "There have been changes with management on some units, but I am very supportive to the staff. I spend a lot of time walking the floors, but I can't sort everything out. The attitude of the staff is changing. We need to get across that you work for BUPA and you work for the home, not just each floor you work on". We saw through staff meeting minutes that managers were aware of the issues, and had asked for staff to be aware of relationships in the team and maintain professionalism.

The culture of a home directly affects the quality of life of residents. A positive culture has the ethos of care built around the resident, and acknowledges the importance of fostering positive relationships between residents, relatives and staff as the foundation to quality of life. Staff working as an effective team, with mutual appreciation and some blurring of roles, improves team performance and will impact positively on the quality of life for people and the wellbeing of staff. We have identified the above concern as an area of practice that requires improvement.

Despite the above concerns, staff did tell us they felt well supported by the registered manager and described her 'open door' management approach. One member of staff told us, "The manager is brilliant. I would happily knock on her door and ask for help. She listens and I've never had a problem with her". Another said, "The home manager is approachable and tries to sort out any problems". A further member of staff added, "They can phone the manager on her mobile if they need her. She is supportive and will work on the floor as a care worker if needed, she has done in the past".

There were systems of communication, such as handovers between shifts, which were thorough and staff discussed matters relating to the previous shift. Additionally any other pertinent information was recorded in a communications book, for example if a person was currently taking antibiotics. The registered manager informed us that they attended regular management meetings to discuss areas of improvement for the service and review any new legislation within the sector. They were supported by the regional manager. These meetings were an opportunity to discuss

Requires Improvement

Is the service well-led?

and analyse any issues with the home. Additionally, information around the latest developments in the care sector and communications from the BUPA head office were discussed, so that they could be cascaded to all staff at the home.

People were actively involved in developing the service. For example, one person told us they had made a suggestion about the times that meals were served. They told us they had raised this with the registered manager and this had been implemented. We saw two people had been assisted to bring their own beds to the home. We also saw the service regularly arranged meetings at the home and in the community for people and their families with Admiral Nurses from Dementia UK. Admiral Nurses are specialist dementia nurses who give practical and emotional support to families, as well as the person with dementia. They offer support to families throughout their experience of dementia that is tailored to their individual needs and challenges. They provide families with information to understand the condition and its effects, the skills and tools to improve communication, and provide emotional and psychological support to help family members. Further information was also made available for people to access other local services and care groups.

The provider undertook quality assurance audits to ensure a good level of quality was maintained. For example, an audit highlighted that care staff supervision meetings had fallen behind and an action plan to bring these meetings up to date had been developed. Questionnaires were sent out to families and feedback was obtained from people, staff and involved professionals. Returned questionnaires and feedback were collated, outcomes identified and action taken. The information gathered from regular audits, monitoring and the returned questionnaires was used to recognise any shortfalls and make plans accordingly to drive up the quality of the care delivered.

Accidents and incidents were recorded and staff knew how and where to record the information. Remedial action was taken and any learning outcomes were logged. Steps were then taken to prevent similar events from happening in the future. For example, after analysis of an incident involving a person's medication, a GP was contacted and a new procedure of recording and administering was put in place.

Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had. They reported that manager's would support them to do this in line with the provider's policy. We were told that whistle blowers were protected and viewed in a positive rather than negative light, and staff were willing to disclose concerns about poor practice. The consequence of promoting a culture of openness and honesty provides better protection for people using health and social care services.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had not ensured that people were protected from receiving care that was unsafe or inappropriate. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.