Excel Care Homes Limited

Aniska Lodge

Inspection report

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Warninglid
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 13 July 2016 and was unannounced.

Aniska Lodge is a nursing home for up to 49 people. It provides care and support to adults but predominantly older people with residential or nursing care needs, and people living with dementia or a physical disability. At the time of our inspection there were 44 people living at the service. The service is purpose built, arranged over three floors accessed by two passenger lifts, and situated in the village of Warninglid just off the A23. The ground and top floor was used to provide people with residential and nursing care, support and treatment while the middle floor was used to provide care for people living with dementia. Long term care and respite care was provided.

There was a registered manager for the service. 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.

The last inspection was carried out on 12 and 14 May 2015. We found a number of breaches to the Regulations. This was in relation to safe care and treatment, staff awareness about the care provided to people who did not have capacity to make decisions about their care and treatment, the environment people lived in and recruitment practices. We also found areas which needed improvement in relation to the quality assurance processes in place, the environment and medicines administration guidance and recording. The provider provided the CQC with an action plan as to how they would address these issues. We looked at the improvements made as part of this inspection. At this inspection we found the provider had followed their action plan, improvements had been made and the regulations were now being met.

Feedback from visiting health and social care professionals was that there had been significant improvements to the care provided. Staff told us there had been significant improvements made to the service provided since the last inspection. One member of staff told us, "There have been a lot of changes since (registered manager's name) started. Paperwork has improved. Staff are more relaxed. I consider her (the registered manager) not like a friend, but we communicate very well. The door is always open we can go to her office anytime. The building has changed a lot. There is the quiet room now and the building all-over looks so much better now than before."

People were cared for by staff who had been through safe procedures. Recruitment checks such as a criminal records check and two written references had been received prior to new staff working in the service. Staff told us they were supported to develop their skills and knowledge by receiving training which helped them to carry out their roles and responsibilities effectively. Training records were kept up-to-date, plans were in place to promote good practice and develop the knowledge and skills of staff. Senior staff monitored peoples dependency in relation to the level of staffing needed to ensure people's care and support needs were met. However, on the day of the inspection we observed the deployment of staff during

the day did not ensure all people's care and support needs identified were fully met. Care staff were very busy meant areas of the service did not did not ensure people had access to care staff when needed. This is an area in need of improvement.

There was a maintenance programme in place which ensured equipment and service were regularly checked, and repairs were carried out in a timely way. There were areas where the décor and furnishings was still in need of updating to improve the environment people lived in. However, the provider had an action plan to address this which they were working through. This had ensured that there had been improvements to the environment since our last inspection. For example, there was a programme for replacing the beds, floor coverings, external decoration and repair and internal decoration. Following feedback from people a new hairdressing salon had been created. On the middle floor there was a new quiet lounge where people could go if they wanted to be away from the larger busier lounge.

People felt safe in the service. One person told us, "Yes, very safe. There is always someone around." Another person told us, "I do. It's really good here. They really look after me." A visitor told us, "It's very safe and very good. I took care of him for a good while and am happy to think he is well cared for. He is very happy here." People were supported by care staff who were trained in safeguarding adults at risk procedures and knew how to recognise signs of abuse. There were systems in place that ensured this knowledge was checked and updated. People knew who they could talk with if they had any concerns. They felt it was somewhere where they could raise concerns and they would be listened to. Accidents and incidents had been recorded and appropriate action had been taken and recorded by the registered manager.

Care and support provided was personalised and based on the identified needs of each individual. People were supported where possible to develop and increase their independence. People's care and support plans had been reviewed and updated and were detailed. People felt involved in making decisions about their care and treatment and listened to. People's healthcare needs were monitored and they had access to health care professionals when they needed to. Detailed risk assessments were in place to ensure people were safe when they received care and support. Where people had been assessed at risk or developing pressure sores, or from falling out of bed, the equipment identified to be used had been regularly checked to ensure it remained suitable for individual peoples use.

People told us they got their medicines on time. One person told us," I would forget so it's good that they look after my medication." There were systems in place to ensure that medicines were ordered, stored, administered and reviewed appropriately. Where medicines were administered on an 'as and when' basis (PRN) such as pain relief there was detailed guidance in place to direct staff on its administration. Records completed such as the medicines administration records (MAR) and where creams had been applied had been fully completed.

Consent was sought from people with regard to the care and treatment that was delivered. Care staff understood about people's capacity to consent to care and had a good understanding of the Mental Capacity Act 2005 (MCA) and associated legislation. Where people were unable to make decisions for themselves, staff had considered the person's capacity under the Mental Capacity Act 2005, and had taken appropriate action to arrange meetings to make a decision within their best interests. Referrals had been made for Deprivation of Liberty Safeguards (DoLS) and we could see that staff understood how these were implemented. The majority of people told us staff always asked their consent before helping with any care or treatment. One person told us, "Oh yes they always ask before they come in and tell me what they want and ask if it's ok." Another person told us, "Yes always." Another person told us, "Always, they explain everything they do."
People were supported by kind and caring staff. One person told us, "Kind and considerate, always available

if I need them. Another person told us, "They are very good. Another person told us, "They are yes. They take time to chat and we have a laugh." Another person told us, "Very much so. When I was poorly they kept checking on me and make sure I did my hair and makeup." People were treated with respect and had their privacy and dignity maintained by the staff. They were spoken with and supported in a sensitive, respectful and professional manner. One person told us, "They always keep bathroom door closed when assisting me." People told us the food was good and plentiful. One person told us, "It's good and plentiful. There are always drinks available. Another person told us, "Can't fault the food. We have drinks all day." Staff told us that an individual's dietary requirements formed part of their pre-admission assessment and people were regularly consulted about their food preferences.

People told us they thought the service was well led. One person told us, "I am very happy here." Another person told us, "It's very good." Staff told us that communication throughout the service was good and included comprehensive handovers at the beginning of each shift and regular staff meetings. They confirmed that they felt valued and supported by the managers, who they described as very approachable.

People and their representatives were asked to complete a satisfaction questionnaire, and people had the opportunity to attend residents meetings. They knew who to talk with if they had any concerns. We could see the actions which had been completed following the comments received. The registered manager told us that senior staff carried out a range of internal audits, and records confirmed this. The registered manager also told us that they operated an 'open door policy' so people living in the service, staff and visitors could discuss any issues they may have.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were cared for by staff been recruited through safe recruitment procedures. Staffing levels were monitored to ensure there were enough staff to meet people's care needs.

People had individual assessments of potential risks to their health and welfare, which had been regularly reviewed. Equipment identified to be used had been checked and maintained to meet people's individual requirements and to fully protect people.

The building and equipment had been subject to regular maintenance checks. There were areas where the décor was in need of updating to improve the environment people lived in. However, an action plan was in place and being followed to address this.

Medicines were stored appropriately. There was guidance for care staff to follow when administering medicines 'as and when'(PRN).

Is the service effective?

Good

The service was effective.

Staff were aware of their responsibilities from the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS.) Where people lacked capacity to make decisions about their care and treatment this had been considered in their best interests.

Staff had a good understanding of peoples care and support needs. People were supported by staff that had the necessary skills and knowledge.

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 when they needed.

Is the service caring?

Good

The service was caring.

Staff involved and treated people with compassion, kindness, dignity and respect.

People were treated as individuals. People were asked regularly about their individual preferences and checks were carried out to make sure they were receiving the care and support they needed.

People told us care staff provided care that ensured their privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The deployment of staff in the service did not ensure people always received the care and support they needed.

People had been assessed and their care and support needs identified. Detailed care plans were in place to ensure people received care which was personalised to meet their needs, wishes and aspirations.

People were supported to take part in a range of recreational activities both in the service and in 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 were comfortable talking with the staff, and told us they knew who to speak to if they had any concerns.

Is the service well-led?

Good

The service was well led.

The leadership and management promoted a caring and inclusive culture. Staff told us the management and leadership of the service was approachable and very supportive.

Quality assurance was used to monitor and to help improve standards of service delivery.

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.

Aniska Lodge

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 took place on 13 July 2016 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor in nursing care and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience helped us to get feedback from people being supported and their visitors.

Before the inspection, we reviewed information we held about the service. This included previous inspection reports, and any notifications, (A notification is information about important events which the service is required to send us by law) and complaints we have received. This helped us to plan our inspection. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We telephoned the local authority commissioning team, who have responsibility for monitoring the quality and safety of the service provided to local authority funded people. We contacted visiting health and social care professionals for their experience of the care and support provided and received three responses.

We used a number of different methods to help us understand the views and experiences of people, as they not all were able to tell us about their experiences due to their living with dementia. 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. We used this tool to observe the experience of people living with dementia on the middle floor. We spoke with nine people, and three visitors who were friends or relatives. We spoke with the providers, the registered manager, the deputy manager, two registered general nurses (RGN), five care workers, a laundry assistant, two activity co-ordinators, a cook and a chef/maintenance person. We spoke with two visiting health care professionals to ask them about their experiences of the service provided. We observed medicines being administered, the care and support

provided in the communal areas, activity sessions and the mealtime experience for people over lunchtime throughout the service.

We looked around the service in general including the communal areas, a sample of people's bedrooms, and the garden. As part of our inspection we looked in detail at the care provided to 10 people, and we reviewed their care and support plans. We looked at menus and records of meals provided, medicines administration records, the compliments and complaints log, incident and accidents records, records for the maintenance and testing of the building and equipment, policies and procedures, meeting minutes, staff training records and five staff recruitment records. We also looked at the provider's own improvement plan and quality assurance audits.

The last inspection was carried out on 12 and 14 May 2015.

Good

Is the service safe?

Our findings

People and their visitors told us they felt people were happy and were well treated in Aniska Lodge. We asked people if they felt safe in the service. One person told us, "Yes it's very good." Another person told us, "Very safe. Lots of nice people." Another person told us," Yes, always has been a safe environment. We asked staff how they made sure people were safe. One member of staff told us, "We mainly do it by reassuring and orientating people in time and place. We have regular fire checks. We make sure the hoists and slings are used properly. There are no trip hazards. We explain if they are fearful. We talk to families if people are anxious."

At the last inspection on 12 and 14 May 2015, the provider was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This was because recruitment checks had not been fully carried out prior to staff commencing work in the service. There was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because equipment had not always been used correctly which put people at risk. Areas were also identified as in need of improvement. The guidance staff followed for the administration of medicines given on an 'as and when needed' (PRN) basis, was not fully in place, and records for the application of topical creams not always fully completed. Areas of the environment in which people lived were in need of improvement. During this inspection, we found improvements had been made and issues identified had been rectified. The regulations were now being met.

At the last inspection on 12 and 14 May 2015 we found people were cared for by staff who had not all been recruited through safe recruitment procedures. Where staff had applied to work at Aniska Lodge they had completed an application form and attended an interview. Each member of staff had undergone a criminal records check and had two written reference requested. Where registered nurses were being recruited we saw that checks had been made on their pin number. This is an information system which can be accessed to ensure nursing staff were still registered to work as a nurse provided nursing care. However, not all of these checks had been received prior to the new member of staff commencing work in the service. Staff had commenced work prior to all the references and criminal records checks being received. This meant that not all the information required had been available for a decision to be made as to the suitability of a person to work with adults. This placed people at risk of receiving care from the wrong staff as appropriate checks hadn't taken place. At this inspection we found the issues highlighted had been addressed and all checks had been completed prior to the new member of staff commencing work in the service. We looked at the recruitment documentation for five new members of staff recruited to work in the service. A checklist had been implemented and 'signed off' when each stage of the recruitment process had been completed. The registered manager then agreed the recruitment process had been fully completed before new staff started to work in the service.

People had an air mattress (inflatable mattress which could protect people from the risk of pressure damage) where they had been assessed as high risk of skin breakdown (pressure sore). These were set to meet people's individual requirements. At the last inspection on 12 and 14 May 2015 we found the checks to ensure the mattress continued to be at the right setting had not been maintained. Where people had a bed

rail on their bed to prevent them falling out, we observed bed rail bumpers, which covered the rails to give people further protection and comfort had not always been used. At this inspection we found these concerns had been addressed. The deputy manager showed up the checks completed for the air mattresses and how the correct settings had been maintained. We observed the use of bed bumpers where people had a bed rail on their bed.

At the last inspection on 12 and 14 May 2015 we found where people took medicines on an 'as and when' basis (PRN) there was limited guidance in place for staff to follow to ensure this was administered consistently. This was to ensure care staff could tell how and when this medication should be given. The completion of the body maps to direct staff as to where the cream should be applied and the recording of the application of topical creams had not been consistently completed. At this inspection we found clear guidance as to when medicines PRN medicines should be taken was now in place, and included how often for how long before further guidance from a GP should be sought, to ensure people's medicines were administered consistently. Where topical creams should be applied for individual people, the body maps in people's records had been completed to ensure all staff were clear on the required application, and recorded when applied.

People told us they got their medicines when they needed them. One person told us, "They control my medication. They are very good at giving it when required." Another person told us, "Yes they come at the same time usually." Another person told us, "Yes and yes it's on time." People who were able to could be supported to manage their own medicines through a risk management process. 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 and we found these had been fully completed. Medicines were stored correctly and there were systems to manage medicine safely. Regular audits and stock checks were completed to ensure people received their medicines as prescribed. We looked at a sample of the medications in stock. We found the records of the stock of medicines were accurate. This meant staff had an accurate record of the medicines in stock, which they needed when re-ordering people's medicines.

The provider had a refurbishment action plan, Maintenance staff were following this to complete the work identified. However, we found there had been significant work undertaken to improve the environment people lived in. For example the outside of the property was being painted and window sills were being repaired. There was a programme of redecoration and replacement of floorings in place for 2016. The communal areas and a number of the bedrooms had been repainted and had new flooring. Beds were being replaced and new pictures and decorative items had been used to make the service more homely.

Equipment had been regularly checked and serviced. Regular tests and checks were completed on essential safety equipment such as emergency lighting, the fire alarm system and fire extinguishers. External providers and a dedicated maintenance worker was responsible for the servicing and maintenance. Staff confirmed that any faults were repaired promptly and told us regular checks and audits had been completed in relation to fire and health and safety. Records confirmed these checks had been completed. Contingency plans were in place to respond to any emergencies, flood or fire. Staff told us they had completed health and safety training. There was an emergency on call rota of senior staff available for help and support.

The provider had a number of policies and procedures to ensure care staff had guidance about how to respect people's rights and keep them safe from harm. These had been reviewed to ensure current guidance and advice had been considered. This included clear systems on protecting people from abuse. The registered manager told us they were aware of and followed the local multi-agency policies and procedures

for the protection of adults. They had notified the Commission when safeguarding issues had arisen at the service in line with registration requirements, and therefore we could monitor that all appropriate action had been taken to safeguard people from harm. Care staff told us they were aware of these policies and procedures and knew where they could read the safeguarding procedures. We talked with care staff about how they would raise concerns of any risks to people and poor practice in the service. They had received safeguarding training and were clear about their role and responsibilities and how to identify, prevent and report abuse. One member of staff told us, "I would need to make sure of the resident's safety and then inform my manager. If it was very urgent I would contact the police." Another member of staff told us, "I would not share it with the general staff, but inform the manager straight away. Depending on what the disclosure was, it may have to go much higher or be reported to the police." Another member of staff told us, "I should inform the manager, or safeguarding people number is in the nurse's room."

There was a whistle blowing policy in place. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. The care staff we spoke with had a clear understanding of their responsibility around reporting poor practice, for example where abuse was suspected. They also knew about the whistle blowing process and that they could contact senior managers or outside agencies if they had any concerns.

People had individual assessments of potential risks to their health and welfare and these were reviewed regularly. Where risks were identified, staff were given clear guidance about how these should be managed. Staff also told us if they noticed changes in people's care needs, they would report these to one of the managers and a risk assessment would be reviewed or completed. We also looked at a sample of people's repositioning charts in their rooms. This was where people were supported to change position as part of their care plan to help protect people and all were fully completed.

Staff told us how staffing was managed to make sure people were kept safe. The deputy manager demonstrated she knew the people well and showed us the dependency tool they used to help ensure that there were adequate staff planned to be on duty. They told us each day they were on duty they went around and met all the people resident. They also regularly worked in the service to keep up-to-date with peoples care and support needs which helped them when compiling the rota. Staff told us although at times it could be busy there was adequate staff on duty to meet people's care needs. They told us minimum staffing levels were maintained. The registered manager told us it had been difficult to recruit new staff. To assist the recruitment of new staff transport to and from the service to key nearby areas had been implemented. Agency staff were used to cover staff vacancies in the service, and feedback from all staff was that this was usually the same agency staff who had worked in the service for a significant period of time. All staff also spoke of good team spirit. People and visitors told us there were enough staff on duty to meet people's needs. Rooms an emergency call bell which people could press if they required urgent attention and a call bell to press if they required assistance. We found that call bells were answered promptly by staff on the day of the inspection. People told us when they called for assistance they received help in a timely way. A sample of the records kept of when staff had been on duty and how many showed that the minimum staffing level was adhered to.

The PIR detailed, 'Staff understand the needs of the residents they are caring for; for example they know the triggers for behaviour changes and the risks related to a resident's care. Staff respond appropriately if a person's behaviour changes to reduce the possibility of either the resident, or residents near them getting upset or anxious. This is to protect them from psychological harm.' Care staff were able to tell us what was in place to support people, the training they completed, and could talk about individual situations where they supported people, and what they should do to diffuse a situation. One member of staff told us the training they had completed, "Helps with behaviour, is written in the care plan and identifies what can be a trigger."

Another member of staff told us, "Last year we had challenging behaviour training. It's more about talking with people, and trying to reassure them." Another member of staff told us, "If a resident is agitated leave them to calm down and try a different face(another member of staff)."Care staff had the opportunity to discuss the best way to support people through regular reviews of peoples care and support and from feedback from the care staff in team meetings as to what had worked well and not worked well. From this they could look at the approach staff had taken and identify any training issues. Staff maintained records of changes in people's behaviours or preferences. These regular reviews of these changes enabled staff to be responsive and captured learning to reduce risks of further incidents.

Good

Is the service effective?

Our findings

People and the visitors told us they felt the care was good. One person told us, "Staff are knowledgeable. They always ask and give opinions." People told us they liked the food provided. One visitor told us, "The residents get a full English breakfast and visitors are always offered tea or coffee and when I come we have lunch together always."

At the last inspection on 12 and 14 May 2015 there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found there were areas of people's care which had been omitted to be considered as a potential deprivation of people's liberty. During this inspection, we found improvements had been made and issues identified had been rectified. The regulations were being met.

At the last inspection on 12 and 14 May 2016 we found many people had bed rails in place. Under the Mental Capacity Act (MCA) 2005 Code of Practice, where people's movement is restricted, this could be seen as restraint. Bed rails are implemented for people's safety but do restrict movement. Bed rail risk assessments were in place for all people where bed rails were used. However, the bed rail risk assessment did not document whether the person consented to the bed rails or if the bed rails were implemented in their best interest. For people who could not consent to bed rails, mental capacity assessments had not been completed. Assessment of capacity should be undertaken to ascertain if the person could consent to the restriction of their freedom (bed rails). If not, it must be explained why the bed rails were implemented in their best interest and if other options were explored. We also found one person sitting in their wheelchair was being supported with the use of a lap belt to help keep them in a comfortable position. This practice had no evidence that a risk assessment had been completed, there was no record as to if this person had consented to the use of the belt, or that it was being used in their best interest. At this inspection we found the risk assessment had been undertaken, mental capacity assessments undertaken where indicated and the appropriate paperwork in place.

Care was provided to people living with dementia on the middle floor of the service. At the last inspection on 12 and 14 May 2016 we found people were not able to move around the middle floor freely because a wooden gate restricted them from going to their bedrooms and to the patio garden. There were no specific risk assessments within care plans about people's ability to use steps safely and the support they needed. At this inspection we found a risk assessment had been undertaken and the appropriate paperwork in place.

All staff demonstrated an understanding and there were clear policies around the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). 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. We checked whether the service was working within the principles of the MCA. All staff told us they had

completed MCA training and had a good understanding of consent, and what procedure to follow if people lacked the capacity to make decisions about their care and welfare. We could see how DoLS had been considered in the service and applications had been made where indicated.

People told us they were asked for their consent before any care and treatment was provided. One person told us, "Yes they always ask me before I have a bath or before they give me my medication." Care staff told us they had completed this training and all had a good understanding of the need for people to consent to any care or treatment to be provided. One member of staff told us, "There is online training in MCA for all staff including the cleaners. "We asked care staff what they did if a person did not want the care and support they were due to provide. One member staff told us, "If that person does not like me I will send for another person. Or I will try again later." Another person told us, "We try to talk to them and encourage them." A further member of staff told us, "Today someone would not eat for a member of staff, but ate fine for me."

People were supported by care staff that had the knowledge and skills to carry out their role and meet individual peoples care and support needs. The registered manager told us all care staff completed an induction before they supported people. One member of staff told us, "There's a two week induction. New staff can't start without moving and handling training. New staff have a mentor. They explain everything and answer any questions. There's an induction book they complete. The team leaders and senior staff mentor." This was confirmed by the records we looked at. The induction had been reviewed to incorporate the requirements of the new care certificate. This is a set of standards for health and social care professionals, which gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. There was a period of shadowing a more experienced staff member before new care staff started to undertake care on their own. The length of time a new care staff shadowed was based on their previous experience, whether they felt they were ready, and a review of their performance. New members of the care staff told us they had received an induction. This had provided them with all the information and support they needed when moving into a new job role.

Staff received training to ensure they had the knowledge and skills to meet the care needs of people living in the service. Care staff received training that was specific to their role and the needs of people using the service, which included training in moving and handling, medicines, first aid, safeguarding, health and safety, food hygiene, equality and diversity, and infection control. Additionally nursing staff had been supported and provided with information on courses they could attend at a local hospital to keep their clinical skills updated and current. They told us they had completed training this year relevant to the care provided in the service, for example they had all had catheterisation training to provide care to male and female people resident; they had attended venepuncture training. The nursing staff each took a lead in each specific area of care and attended further training for example, in wound care, malnutrition and 'Train the Trainer' in moving & handling and medication management in order to ensure standards in the service were maintained. The nursing staff told us they felt well supported, they were able to ask for training courses, and were given clinical supervision.

The training completed was given through a mixture of ELearning packages, accessing external providers, staff being trained to be a 'Train the Trainer,' or practical sessions. Care staff spoke of training they had attended to help them understand and support people living with dementia. Staff told us that further dementia care training was to be provided particularly for new care staff who had joined the service. Two members of care staff had completed dementia mapping training. This approach prepares staff to take the perspective of the person with dementia in assessing the quality of the care they provide. It supports staff teams to engage in an evidence-based critical reflection in order to improve the quality of care for people living with dementia.

Staff told us that the team worked well together and that communication was good. They told us they were involved with any review of the care and support plans. They used shift handovers, and a communications book to share and update themselves of any changes in people's care. They had all received supervision from their manager, they felt well supported and could always go to a senior member of staff for support. The registered manager told us staff were provided individual supervision and appraisal. This was through one-to-one meetings. These processes gave care staff an opportunity to discuss their performance and for senior staff to identify any further training or support they required. There was a supervision and appraisal plan in place which the registered manager and deputy manager were following to ensure staff had regular supervision and appraisal. One member of staff told us, "Yes it's good and helpful. I use this as a meeting to discuss the problems with her, and she listens a lot. "Additionally there were regular staff meetings to keep staff up-to-date and discuss issues within the service.

People told us they enjoyed the food provided. One person told us, "It's not bad, yes really quite good. There is plenty to drink. I don't have any dietary requirements." Another person told us, "It's very good they take care of meals well. Drinks,oh yes plenty." Another person told us, "Food is brilliant. I eat in my room. Yes they know my requirements. I prefer to eat here as I hate the hoist." People's nutritional needs were assessed and recorded, and people's likes and dislikes had been discussed as part of the admissions process. Records were accurately maintained to detail what people ate to inform staff if people had had adequate food and fluid during the day. Some people had food and fluid intake charts. They relied on care staff to ensure they had enough to eat and drink throughout the day. We found that these had been fully completed to ensure care staff a clear and full picture of if people had received adequate fluids during the day to maintain their wellbeing.

People's weights were monitored regularly with people's permission and there were clear procedures in place regarding the actions to be taken if there were concerns about a person's weight. For example where a person had lost weight more frequent checks of their weight had been carried out and their diet reviewed and a fortified diet considered. We looked at a sample of the weight charts; some residents were being weighed weekly, some fortnightly and others monthly according to need and as detailed in their care and support plan. These were all up to date and fully completed.

The cook told us there was a seasonally changed rotating menu, which was based on people's likes and dislikes. They met any new people living in the service to discuss with them their likes and dislikes. Two options were always available, and we found that people could also make additional requests if there was nothing on the menu that they liked. This information was then fed back to the cook. A copy of the menu was available in the service in a pictorial format to help people with their meal choice. However, for people living in the dementia on the middle floor this had not been updated for several days, so people were not aware in advance of the options available. We discussed this with the registered manager on the day and this was rectified. The cook was aware of people's individual dietary requirements, and the likes and dislikes of each person. They were able to tell us who required a fortified diet, and we observed fortified drinks and snacks were provided during the day. One person on a special diet told us. "I get special meals as I have kidney problems. They're really quite good." This showed us that staff were aware of individual's preferences, needs and nutritional requirements. Twice a week the cook completed a survey with five people to get feedback on the food provided.

People were supported to maintain good health and received healthcare support. People's physical and general health needs were monitored by care staff and advice was sought promptly for any health care concerns. Care plans contained multi-disciplinary notes which recorded when healthcare professionals visited such as GPs, social workers, nurses or dieticians and when referrals had been made. For example, for one person there was evidence they had been referred to the proactive team and physiotherapist to help

build up upper body strength. There was a record in the notes of the proactive team attending with a list of exercises from physiotherapist. For another person who had a PEG feed (a procedure to assist the person to eat through a tube) there was a clear PEG feeding information chart. They had been reassessed by the community rehabilitation neuro team. There was clear guidance that the person must be at a 40 degree elevation (head and shoulders) during the feed and for one hour post-feed." For another person on end of life care, they had been assessed by the speech and language team (SALT). There were clear swallowing guidelines in place. Feedback from the healthcare professionals we spoke with supported this. One visiting healthcare professional told us, "There are regular nurses now, who know the patients well, and who liaise with the patients families. "Care staff told us that they knew the people well and if they found a person was poorly they should report this to the manager.

Where people were receiving palliative care, a care plan had been drawn up to give care staff guidance as to how to support people. Further advice and guidance had been sought from a local hospice and healthcare professionals. For example for one person receiving palliative care there had been a recent assessment by the speech and language team (SALT.)The person's notes stated, 'Staff can try to offer food on a teaspoon, sips of thickened fluids and regular mouth care.' During the day we looked at the recording chart which showed the mouth care had been carried out. There was also an observation chart which showed they had been checked every 15 minutes, and a repositioning chart had been completed two hourly.

Good

Is the service caring?

Our findings

People and their visitors told us people were treated with kindness and compassion in their day-to-day care. They told us they were satisfied with the care and support people received. They were happy and they liked the staff. One person told us, "Yes they are kind and caring. They seem to deal very well with things." Another person told us, "They are very good. They will always ask if I am unhappy." Another person told us, "Yes they are. I get on with everyone."

Staff told us they enjoyed working in the service. One member of staff told us, "I love it here, I love the people, the residents, everything." Another member of staff told us, "I love working here. I cannot think of anything to improve here. I've been here nine years, that tells you everything." During our inspection we spent time in the communal areas with people and staff. We saw people were treated with kindness and respect. For example, we observed one member of staff assisting one person to eat a pureed lunch. The person was expressing general displeasure and the member of staff was kind and patient in attempting to engage with them. People were seen to be comfortable with staff and frequently engaged in friendly conversation.

Where possible people were consulted with and encouraged to make decisions about their care. People told us they felt listened to. Care provided was personal and met peoples individual needs. A key worker system was in place, which enabled people to have a named member of the care staff to take a lead and special interest in the care and support of the person the keyworker. One member of staff told us, "I always make sure my resident is clean and tidy. It's how you would like your own Nan to be treated." People were addressed according to their preference and this was mostly their first name. Staff spoke about the people they supported fondly and with interest. People's personal histories were recorded in their care files to help staff gain an understanding of the personal life histories of people and how it affected them today. Care staff answered questions, gave explanations and offered reassurance to people who were anxious. Staff responded to people politely, giving people time to respond and asking what they wanted to do and giving choices. We heard staff patiently explaining options to people and taking time to answer their questions. Staff were attentive and listening to people, and there was a close and supportive relationship between them. Care staff demonstrated they were knowledgeable about people's likes, dislikes and the type of activities they enjoyed. Staff spoke positively about the standard of care provided and the approach of the staff working in the service.

People were cared for by kind and caring staff. One person told us, "When I was poorly they kept checking on me and make sure I did my hair and makeup." The PIR detailed,' The home has a culture of compassionate care and we embrace the values of the 6 C's , care, compassion, competence, communication, courage, and commitment. Staff continue to be supported to attend training and professional development courses that will enable them to support the residents according to their individual needs in a caring manner promoting and respecting their dignity, privacy and respect at all times. It is very important that the residents feel valued in the home and special occasions, such as birthdays, anniversaries, etc. continue to be celebrated for the enjoyment of the residents.' This was demonstrated during the inspection.

People told us care staff ensured their privacy and dignity was considered when personal care was provided. One person told us, "Oh yes. They are very good. They close the door if they are giving me a wash." Another person told us, "Definitely." We spoke with the dignity champion for the service. The registered manager and a member of the care staff had recently completed training to be 'Dignity Champions' in the service. One member of staff told us, "The manager and I have just done the NHS dignity training. We printed of the 10 key points and gave this to staff." They showed us the '10 Dignity Do's', which described the values and actions for staff to follow to respect people's dignity. They told us they had completed a questionnaire with people to identify their thoughts on what was needed to ensure their privacy and dignity. Following this work was completed with staff using people's feedback to generate discussion. For example ensuring that care staff covered people when in the bathroom, and improving communication between care staff and people when providing care to people. One member of staff told us, "It's bringing big improvements. Each month this will be a standing agenda item at our meeting to jog people's memory." Care staff had received training on privacy and dignity and had a good understanding of dignity and how this was embedded within their daily interactions with people. They were aware of the importance of maintaining people's privacy and dignity, and were able to give us examples of how they how protected people's dignity and treated them with respect. We observed staff knocked on people's doors and waited before entering, and the use of screens when people were being hoisted. In people's care notes reference in the personal hygiene section there was a record that people had been asked if they would like male or female care workers to assist or whether they did not mind. All the detailed what name the person preferred to be called. The care plans also provided detailed explanations on communication, enabling all staff to understand the best way to communicate with individual people. For example in one care plan it detailed, 'I may need assistance with (name of treatment) but maintaining privacy and dignity is very important to me. I have no preference to gender of the person who assists me.'

The atmosphere in the service was calm and relaxed, but there was also a general hum of activity. People had their own bedroom and ensuite facility for comfort and privacy. The PIR detailed, 'Where possible people were encouraged to choose the colour of the walls in their room.' The registered manager told us the communal areas had been repainted and over half of the bedrooms, with the rest were due as part of the refurbishment plan. People had been able to bring in items from home to make their stay more comfortable such as small pieces of furniture, pictures and ornaments. One person told us, "I could but haven't." Another person told us, "Yes. I have lots of things from my home." Another person told us, "I have some pictures." Work had continued to make the middle floor more dementia friendly for the people living there. At this inspection we found there had been improvements to the environment in which people lived. For example, doors to people's bedrooms had been decorated to be a front door of their room. Care staff told us that picture boxes had been purchased to be filled with items important to people and were to be placed next to their door. There was now signage in place to help direct people. Decorations included people's own art works and new pictures had been purchased. There was a programme for the replacement of the flooring on the middle floor. One room had been changed into a further seating area where people could sit quietly away from the main group. The garden for use by people living with dementia on the middle floor was being improved.

People had been supported to keep in contact with their family and friends. Visitors told us there was flexible visiting. One visitor told us they regularly took their relative out. Another visitor told us they could sit and have lunch with their friend if they wanted to. People had not required support when making decisions about their care from an advocacy service. Senior staff were able to confirm they knew how support people and had information on how to access an advocacy service should people require this service.

Care records were stored securely. Information was kept confidentially and there were policies and procedures to protect people's personal information. There was a confidentiality policy which was

accessible to all staff. Staff demonstrated they were aware of the importance of protecting people's private information. People told us they thought. One person told us, "I would say so." Another person told us, "Yes definitely." Another person told us, "I don't think they discuss me with anyone else."

Requires Improvement

Is the service responsive?

Our findings

Before someone moved into the service, a pre-admission assessment took place. This identified the care and support people required to ensure their safety so staff could ensure that people's care needs could be met in the service. The registered manager told us everyone was visited prior to any admission. If they felt they did not have enough information to make a decision they requested further information. The PIR detailed people were encouraged to visit the service prior to admission and stay for lunch to help them make an informed decision about where they would like to live, records we looked at confirmed this. People knew who to speak to if they had any concerns. There was a complaints system were in place if people had any concerns, but no one we spoke with had had to raise any concerns. One person told us, "I have no concerns." Another person told us, "I haven't had any concerns." However, we found the provider had not ensured the deployment of staff had enabled them to respond to people's needs in a timely way.

The deputy manager showed us how staffing was calculated to ensure there was enough staff on duty to meet their care and support needs. However, on the day of the inspection we observed the care staff were very busy. The deployment of staff during the day meant areas of the service did not ensure people always had access to care staff when needed. For example for people living with dementia on the middle floor for significant periods during the morning there was up to nine people in the lounge being supported by an activities coordinator. This member of staff was trying to provide activities for people, but was also being called upon to also provide personal care and support. This interrupted the activities and social experience for people which could be provided. The information on the menu for the day from which people could choose their meal had not been updated on the middle floor for several days. It was clear from discussions with staff there was a lack of clarity of whose responsibility it was to change this. This meant staff did not have the information in advance to help them spend time with people to choose the meal they would like to eat. In the downstairs lounge during lunchtime, care staff were fully occupied helping people in their bedrooms taking their meal up to them and then assisting them to eat their meals. This meant that the main dining area was not always staffed to support people eating their meal. Whilst we did not identify any harm had occurred as a result of this issue it is an area of practice in need of improvement.

Care staff told us that care and support was personalised and confirmed that, where possible, people were directly involved in their care planning. Where people could not due to their living with dementia, family had been involved in providing important information to help care staff with the delivery of people's care. One person told us, "There is a letter explaining my likes and dislikes." The care and support plans were detailed and contained clear instructions about the needs of the individual. They included information about the needs of each person for example, their communication, nutrition, and mobility. Individual risk assessments including falls, nutrition, pressure area care and manual handling had been completed. There were instructions for care staff on how to provide support tailored and specific to the needs of each person. When asked about their care plan one person told us, "I am not sure I have one. Yes, they know my likes and dislikes." Another person told us, "Yes I am quite aware and it is often reviewed. They know my likes and dislikes They are very good." A further person told us, Yes. It was recently reviewed." A nominated registered

nurse had been allocated for each person to ensure care plans were reviewed and updated. These had been reviewed and audits were being completed to monitor the quality of the completed care and support plans. Where appropriate, specialist advice and support had been sought and this advice was included in care plans. For example, records confirmed that advice and support had been sought from the Parkinson's nurse. During our discussions with staff we found that they knew people and their individual needs and it was evident that they knew them well. Staff demonstrated an understanding of non-verbal communication needs and how to interact with people who could not verbally communicate. Staff told us, when offering choice to people who could not verbally communicate; they used facial expression, body language and gestures to communicate. For example, staff could describe how they used a person's body language to describe if they were happy to have their personal care provided. This showed us that people's communication needs were met.

People and their representatives were able to comment on the care provided through regular reviews of people's care and support plans, in residents and relatives meetings and by completing quality assurance questionnaires. Minutes of the residents meetings held confirmed people had been asked for feedback on the meals provided and for suggestions. For example people expressed the wish to have a hairdressing room and a room had been converted for this purpose. Meal check forms were introduced to gain feedback from people about the meals provided. A dignity champion was appointed. Part of their roles was to talk with staff regarding dignity, the 'Dos and Don'ts,' following feedback received.

The PIR detailed, 'Residents are given a choice of what activities they would like to pursue. One resident would like day services where they can go and make friends. The home has facilitated a referral to a local hospice. Staff also promote residents' individuality for example one residents enjoys spending time in the garden. A huge flower bed was purchased and they took pride in building it and they enjoy going out to tend the plants.' On the day of the inspection a range of activities were organised, for example throwing a ball, poetry reading, and cooking cakes. Activities were facilitated by three activities co-ordinators who between them worked in the service seven days a week. External groups or entertainers were also booked to come in and entertain people. The notice boards had information about activities people could attend, or had attended. Not all the people told us they chose to join in the activities, but were aware they could join in if they wished to. People were being reminded and encouraged to join in the activities on offer on the day. Activities staff told us of a new activity just introduced of a market stall, with for example chocolates, makeup and handbags for sale which people could buy. Memory boxes were being used to store objects of reference to enable care staff to be able to reminisce and be aware of people's interests and hobbies. One member of staff told us, "We try to encourage them as much as possible to join in the activities. But you can't force them." Two members of staff told us what was provided for people who spent most or all of their time in their bedroom. They were able to tell us depending on people's interests and what they wanted to do they listened to music, read to people, spent time talking with them. Records of residents and relatives meetings and quality assurance questionnaires completed confirmed that people had been asked for their views and ideas on activities provided.

People told us they knew who to speak to if they had any concerns, and felt it was an environment they could raise any concerns. One person told us, "The manager I suppose but no I haven't any concerns." Another person told us, "Yes I think so but I have no problems really." Another person told us, "The nurses I suppose. If I have a concern my daughter would sort it." We looked at how people's concerns, comments and complaints were encouraged and responded to. People were made aware of the complaints, suggestions and feedback system which detailed how staff would deal with any complaints and the timescales for a response. It also gave details of external agencies that people could complain to. This information was contained within the service user's guide which was available in people's bedrooms. No one we spoke with had raised any concerns. One person told us, "No concerns. I could raise if I wanted to."

People and their visitors told us they felt listened to and that if they were not happy about something they would feel comfortable raising the issue and knew who they could speak with. Care staff were aware that if people or their visitors had any concerns these should be discussed with the registered manager. In addition to the compliments and complaints procedure, the registered manager told us they operated an 'open door' policy and people, their relatives and any other visitors were able to raise any issues or concerns.

Good

Is the service well-led?

Our findings

People were asked for their views about the service. They said they felt included and listened to, heard and respected, and also confirmed they or their family were involved in the review of their care and support. When asked if people felt the service was well led, one person told us, "I think it is they do a good job really." Another person told us, "Oh yes, definitely." Another person told us, "Very well run." One member of staff told us, "The manager and deputy are very approachable. I could talk to them about anything."

At the last inspection on 12 and 14 May 2015 robust quality assurance processes were not in place, and had not identified issues to be addressed. We found for some complaints the information was limited. Recording did not always evidence what had been done to resolve the complaint, and any feedback given to the complainant. Senior staff had not collated the outcome of any complaints received. Complaints had not been reviewed to identify any themes or trends which could impact on the care that other people received and needed to be addressed. There was no evidence of learning or any change in practice from complaints received. At this inspection we found Senior staff monitored the quality of the service by speaking with people each day to ensure they were happy with the service they received, completing reviews of the care provided, and quality assurance questionnaires. Quality assurance audits had been completed for example to check the quality of the completion of people's care and support plans, and for the administration of medicines and health and safety. 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 for one person after analysis of an incident the falls advisory team were contacted to provide guidance and support. For another person there had been a review of their medicines. We looked at the records of any complaints raised and saw the policies and procedures had been followed with details of the issues investigated and written responses of the outcomes sent to the complainant in a timely way. They were able to show us that following the audits any areas identified for improvement had been collated in to an action plan and how and when these had been addressed. The provider had also engaged an external company to undertake two audits of the service to identify and provide guidance on areas in need of improvement. Each time an action plan had been drawn up and the registered manager was able to tell us of the work completed to address any issues highlighted. At this inspection we found the issues raised had been rectified.

There was a weekly meeting with heads of departments to review and discuss the care being provided. Staff told us this was an opportunity to discuss practices for improvement and what could be improved to enhance people's quality of life. Staff meetings were held each throughout the year. These were used as an opportunity to both discuss problems arising within the service, as well as to reflect on any incident that had occurred. Staff told us they felt they had the opportunity if they wanted to comment on and put forward ideas on how to develop the service.

There was a clear management structure with identified leadership roles. The registered manager was supported by a deputy manager. There was a team of registered nurses and senior care staff. Staff told us the managers were approachable, knew the service well and would act on any issues raised with them. One staff member told us, "The team work has changed. We have a good team now. Moral of the staff is

100%."Staff members told us they felt the service was well led and that they were well supported at work. Another member of staff told us, "Management is very good and very fair. The door is open and they sort things out." The senior staff promoted an open and inclusive culture by ensuring people, their representations, and staff were able to comment on the standard of care provided and influence the care provided.

Feedback from the visiting health and social care professionals was that there had been significant improvements made since the last inspection to the care provided. They spoke of good interactions with staff who contacted them appropriately and followed guidance given.

The organisation's mission statement was incorporated in to the recruitment and induction of any new staff. The mission statement was detailed in the service user's guide for people, visitors and staff to read. The aim of staff working in the service was, "Our main objective is to love and care for residents placed with us, and to give them peace of mind and reassurance, ensuring that they spend the latter part of their lives comfortably and pleasurably." Staff demonstrated an understanding of the purpose of the service, with the promotion and support to develop people's life skills, the importance of people's rights, respect, diversity and an understood the importance of respecting people's privacy and dignity.

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). Senior staff had submitted notifications to us, in a timely manner, about any events or incidents they were required by law to tell us about. There was a policy and procedure on people's responsibility under the Duty of Candour. This is where providers are required to ensure the there is an open and honest culture within the service, with people and other 'relevant persons' (people acting lawfully on behalf of people) when things go wrong with care and treatment. We discussed this with the registered manager during the inspection, who demonstrated an understanding of their responsibilities.