Bamford Care Homes Limited

Quinnell House

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

Summary of findings

Overall summary

We inspected Quinnell House on 6 and 7 February 2017. This was an unannounced inspection. Quinnell House provides accommodation and support for up to 51 people living with dementia. The service no longer provides nursing care on site and uses district nurses to provide support when needed. On the days of our inspection, there were 43 people living at the service. The accommodation is provided in an older style detached building in a residential street. There is a communal lounge, dining room, kitchen, communal bathrooms and bedrooms with en-suite bathrooms. There is also a sensory room and treatment room for use of GP and district nurses.

A manager was in post but they were not the registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run. The manager had been in post nearly six months and was in the process of applying to become the registered manager.

At the last inspection undertaken on the 19 and 20 April 2016, we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 in relation to the principles of the Mental Capacity Act 2005 not being adhered to. People's confidential information had not been maintained and the delivery of care was not consistently person-centred. Recommendations were also made in relation to the use of 'as required medicines' and maintaining accurate and complete records. The provider sent us an action plan stating they would have addressed all of these concerns by June 2016. At this inspection we found the provider had made improvements to the management of 'as required' medicines and people's confidential information. However, improvements were not yet fully embedded and the provider continued to breach the regulations relating to the other areas.

The principles of the Mental Capacity Act (MCA) 2005 were still not consistently applied in practice. People's capacity to consent to the use of bed rails and their bedroom door being locked had not been assessed. Where people were unable to use their call bell to summon assistance, risk assessments were not consistently in place. For people who required two hourly checks to maintain their safely, documentation failed to support that these checks took place.

The risk of social isolation had not consistently been mitigated. The registered provider had failed to maintain accurate, complete and contemporaneous records. People's monitoring charts were incomplete and failed to evidence the level of care that people received. Documentation was in place for the recording of incident and accidents. However, subsequent follow up information was not recorded and incidents and accidents were not audited for any emerging trends, themes or patterns. We have made a recommendation for improvement.

People received their medicines on time and safely. Medicine profiles were in place alongside clear protocols for the use of 'as required' medicines. However, where people received covert medicines

(medicines disguised in food), underpinning documentation was not available to confirm whether the person consented to this or whether it was done in their best interest. We have made a recommendation for improvement.

End of life care plans were not yet consistently in place. Weekly cleaning schedules for the kitchen had not been maintained and the extraction hood in the kitchen had a layer of dust and grease. We have made recommendations for improvement.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate application to restrict people's freedom had been submitted.

The registered provider and manager were committed to the on-going improvement of Quinnell House. The manager told us, "We have a long way to go but we are getting there." Best practice guidelines were followed in relation to dementia care and ensuring the environment was dementia friendly. A 16 week training programme on dementia care had been provided to care staff and staff spoke highly of the training provided.

People were protected, as far as possible, by a safe recruitment system. People and staff felt staffing levels were sufficient and risks associated with the environment were managed. Safeguarding adult's procedures were robust and staff understood how to safeguard the people they supported from abuse. There was a whistle-blowing procedure available and staff said they would use it if they needed to.

Staff had a good understanding of people's needs and treated them with respect and protected their dignity when supporting them. We saw many positive interactions and people enjoyed talking to the staff. The importance of promoting independence was understood by staff and staff told us how they protected people's privacy and dignity.

A range of group activities took place which people spoke highly of. One person told us, "I love the quizzes." People had access to a variety of food and drink and the manager was taking steps to improve people's dining experience.

People, relatives and staff spoke highly of the new manager. One staff member told us, "They've made a lot of positive changes since coming into post and I feel much more supported now." A visiting relative told us, "Quinnell House is the right place for our loved one."

Fire evacuation procedures were in the process of being completed. People had individual maintaining safe and emergency evacuation care plans which considered the level of assistance required to aid a safe evacuation and what equipment would be needed.

During our inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Quinnell House was not consistently safe.

People's individual ability to access the call bell had not consistently been assessed. Where people required two hourly checks to maintain their safety, documentation failed to evidence this.

People told us they felt safe living at the service. There were clear policies in place to protect people from abuse and staff had a clear understanding of what to do if safeguarding concerns were identified.

There were sufficient numbers of staff to safely meet people's needs. There were effective systems in place to manage people's medicines safely.

Is the service effective?

Requires Improvement

Quinnell House was not consistently effective.

The principles of the Mental Capacity Act (MCA) were not consistently applied in practice.

People spoke highly of the food provide but food and fluid charts had not consistently been maintained.

People were cared for by staff that had received training and had the skills to meet their needs. People had access to health care services to maintain their health and well-being.

Is the service caring?

Good

Quinnell House was caring.

People were supported by staff that were kind and caring. Positive relationships had been developed between people and staff. Staff appeared to know people well.

Staff spoke with people and supported them in a very caring, respectful and friendly manner.

People's confidential information was stored securely.

Is the service responsive?

Requires Improvement

Quinnell House was not consistently responsive.

The risk of social isolation had not consistently been mitigated and work was on-going to embed a culture of person-centred care.

People's needs had been assessed and care plans were in place. People felt able to raise any concerns and acknowledged that these concerns would be listened too.

A range of group activities took place which people enjoyed and participated in.

Is the service well-led?

Requires Improvement

Quinnell House was not consistently well-led.

Accurate, complete and contemporaneous records had not been maintained. Further work was required to embed and sustain positive changes.

People spoke highly of the new manager in post and their leadership style. Systems were in the process of being developed to enable people to provide their feedback on the running of the service.

Quinnell House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 6 and 7 February 2017 and was unannounced. The inspection was carried out by two inspectors 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 provider had 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.

Before the inspection we checked the information that we held about the home and the provider. This included previous inspection reports and statutory notifications sent to us by the manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with 12 people, four visiting relatives, seven care staff, a cook, maintenance worker, activities coordinator, acting manager and the provider (owner). We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at nine care plans and associated risk assessments, five staff files, medication administration record (MAR) sheets, incidents and accidents, policies and procedures and other records relating to the management of the service. We also 'pathway tracked' people living at the home. This is when we followed the care and support a person's received and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We lasted inspected Quinnell House on the 19 April 2016 where it was rated 'Requires Improvement.'

Requires Improvement

Is the service safe?

Our findings

People said they felt safe and staff made them feel comfortable. One person told us, "Yes, I am safer than at home, my room is locked safe. No hazards around, good security here." Another person told us, "Yes I want to feel safe here and I do." Visiting relatives also confirmed they felt confident leaving their loved ones in the care of Quinnell House. One relative told us, "The attitude of staff produces a caring and safe atmosphere here." Despite people's positive feedback, we found areas of practice which were not consistently safe.

At the last inspection we identified areas of improvement in relation to the management of pain assessments for people living with dementia and robust protocols were not in place for the use of 'as required' medicines. Recommendations were made and at this inspection, we found improvements had been made.

The management of medicines was safe and people told us they received medicines on time. One person told us, "I get my medication regularly and I understand what it is for." All medicines were securely stored. Full records were maintained of medicines brought into Quinnell House, given to people and disposed of. All staff who supported people with their medicines did this carefully and did not rush people. They gave people the help they needed to take their medicines, including drinks of their choice. They checked each person had fully swallowed their medicine before signing that the person had taken their medicine. Improvements had been made since the last inspection. Where people were prescribed medicines on an 'as required' basis, there were clear protocols outlining the reasons a person needed their medicine and how often it was to be given in 24 hours. For people prescribed 'as required' anti-psychotic medicines, information was provided on the steps to take before administering the medicine and any side effects to be aware of. Medication Administration Records (MAR) charts reflected that where people were prescribed 'as required' anti-psychotic medicines, these were administered on a minimal basis. Systems were now in place to assess people's pain levels and ensure appropriate pain relief was provided to people when required.

Each person had a medicine profile which included information on their date of birth, any allergies and how they liked to receive their medicine. Routine auditing of medicine procedures had taken place, including checks on accurately recording administered medicines as well as temperature checks and cleaning of the medicines fridge. The medicine policy had recently been updated to reflect guidance from the Royal Pharmaceutical Society and The National Institute for Health and Care Excellence.

Where people received their medicines covertly (disguised in food or drink), documentation confirmed this had been approved by the prescribing GP. However, the provider had no underpinning evidence that the person had consented to this or evidence that a mental capacity assessment had been undertaken which determined the individual lacked capacity to consent to the administration of covert medicine.

We recommend that the provider reviews the use of covert medicines in line with best practice and legal guidelines.

People's ability to use and access the call bell had not consistently been assessed. We found that some call bell risk assessments were in place; however, not everyone's ability to use the call bell had been assessed. Where people remained in their bedroom all day, guidance was not consistently in place for how often they should be checked upon. Where guidance was in place, documentation failed to reflect that people were checked on as regularly as assessed. For example, one person's risk assessment identified they were unable to use the call bell to summon assistance and therefore staff should check on them every two hours. However, their daily notes recorded that they could go up to eight hours before staff checked on them. On the 4 February 2017, documentation recorded they were checked on at 12.41pm and not again until 20.01pm. We found this was a consistent theme throughout the service. Staff told us they checked on people regularly. One staff member told us, "We are always in and out of people's bedrooms, and so are the cleaners and other staff members, so people are regularly checked on." The manager told us, "The electronic daily notes are still in their infancy and we are working with staff on the importance of accurate recording."

Throughout the inspection we observed staff coming and going from people's bedrooms, however, where people had an assessed need to check on them every two hours, to ensure they remained safe, documentation failed to evidence that checks had happened. Failure to maintain accurate and complete records is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan. This instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's individual ability to evacuate the building was in the process of being assessed and individualised evacuation plans were being drawn up. We reviewed a sample of evacuation plans that were in place. These considered the level of help people would require. People had individual maintaining safety and emergency evacuation care plans in place which provided additional information on the level of support people required to safely evacuate the building.

Risks to individual's safety and wellbeing had been assessed and people were supported to be safe without undue restrictions to their freedom. For example, where people smoked, they had access to outside space where they could sit down and enjoy their cigarette. Guidance produced by AGE UK advises that older people living with dementia can be at heightened risks of falls. Falls risk assessments were in place which considered the person's age, health conditions, prescribed medicines and other factors. Where people had been assessed as high risk, preventive measures had been introduced such as sensor mats.

Guidance produced by AGE UK advises that for people living with dementia they can display behaviours which challenge, however, these behaviours are a clear expression of their feelings and needs. Staff were knowledgeable about the people they supported and how to respond to behaviours which challenge. One staff member told us, "We have one person who asks regularly to go home and says that they shouldn't be here and they can become quite agitated. When agitated, we find giving them space and going back to talk to them once they have calmed down works." The manager told us, "We have one person who can be against personal care and we've learnt that when they say no, that means no. So in that situation, we ensure they are safe and go back later." This approach was echoed by other staff members we spoke with.

Staff recruitment practices were thorough; people were only supported by staff who had been checked to ensure they were safe and suitable to work with them. Staff records showed that, before new members of

staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). A DBS check helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care and support. All potential employees were interviewed by the manager to ensure they were suitable for the role. All new staff were required to undergo a probationary period during which they received regular opportunities for practice supervision.

Appropriate steps had been taken by the registered provider and manager to reduce the potential risk of people experiencing abuse. Staff members demonstrated a good understanding of the different types of abuse and provided clear explanations of the actions they would take if they thought abuse had occurred. One staff member told us, "Categories of abuse could include, sexual, financial, institutional or neglect." Staff knew where to find information on how to report any concerns to the local authority, who lead on any safeguarding concerns, if they needed to report an incident of concern. Staff confirmed that they had received training in safeguarding people and records confirmed this. The manager had raised safeguarding concerns where required and worked in partnership with the local authority to ensure the safety of 'residents' when concerns had been raised.

There was enough suitably competent staff to keep people safe and meet their needs. People and their relatives felt staffing levels were sufficient. One person told us, "Marvellous staff, couldn't be better, even agency staff, I think on the whole there are enough staff." A dependency tool was in place which provided a baseline of the number of staff required. The manager told us, "We have a dependency tool in place which is helpful; however, for people living with dementia, their needs can change from one day to the next, so we are always reviewing the staffing numbers. We are going to be introducing a fifth member of staff on at night to see what impact that has." From our observations, the service was busy and people and their relatives acknowledged that staff were busy but always made time for people.

Requires Improvement

Is the service effective?

Our findings

People and their relatives had confidence in the staff and told us that the care they provided was effective. One person told us, "Yes they know me, I don't need much support." Another person told us, "Yes on the whole the staff know me and I am involved with my care, no problems." A visiting relative told us, "Staff are lovely, they understand his needs." However, despite people's praise, we found elements of care which were not consistently effective.

At our last inspection in April 2016, the registered provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the requirements of the Mental Capacity Act 2005 (MCA) were not embedded into practice. An action plan had been submitted by the provider detailing how they would meet the legal requirements. At this inspection, improvements were in the process of being made; however, these were not yet embedded.

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. Staff members told us they received training on the MCA 2005 and told us how they worked within the principles of the Act. One staff member told us, "We always assume capacity and remember that people are allowed to make unwise decisions." At the last inspection, the provider had not completed mental capacity assessments for specific decisions, such as the use of bedrooms doors being locked from the outside. Improvements had been made, for example, consent forms had been provided to people and their relatives. However, where people were unable to provide consent, mental capacity assessments had still not been completed. The manager told us, "We are aware of this and we wanted to hold individual discussions with family members beforehand."

A range of decision specific mental capacity assessments had been completed, for example, where people were unable to consent to staff administering their medicines. However, we also found examples where assessments of capacity had not been completed. A number of people received care in bed and bed rails were in place. Bed rails risk assessments had been completed, but documentation failed to evidence if the person consented to the use of bed rails or whether they lacked capacity and they were implemented in their best interest.

Some improvements had been made since the last inspection, consent forms were now in place and decision specific mental capacity assessments were starting to be completed. After the inspection, the acting manager sent us copies of completed mental capacity assessment for the decision regarding people's bedroom doors. We could see that improvements were being made. However, these changes improvements were not yet embedded or sustained and capacity assessments were not consistently in place for specific decisions. This is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased. The manager told us, "A large number of applications are awaiting to be approved, but the applications have been submitted."

Guidance produced by Alzheimer's society advised that 'eating and having a good meal is part of our everyday life and important to everybody, not least to people living with dementia.' With permission, we joined people at lunchtime. Tables were decorated and napkins and cutlery were readily available. The menu was on display and people were given two options or any alternatives. For example, one person didn't fancy the main meal but instead had a jam sandwich. Where people required one to one support with eating and drinking, this was provided in a kind and caring manner. Staff sat down next to the person, clearly explaining what they had and asking what they would like. They also spent time interacting with the person on how their day was. People spoke highly of the food provided. One person told us, "Food is very good, choice of two and drinks whenever I want one." Another person told us, "Food is jolly good, plenty to eat and drink."

Promotion of hydration in older people can assist in the management of diabetes and help prevent pressure ulcers, constipation, incontinence, falls, poor oral health, skin conditions and many other illnesses. People were regularly assessed for nutritional and dehydration risk. Where people were assessed as being at risk, a care plan was put in place to identify how their risk was to be reduced. Staff monitored people's dietary and fluid intake to ensure they received the nutrition they needed and drank enough. However, there was a lack of consistency in some areas, which required improvement. For example, one person's fluid intake chart reflected they were supported to have 100mls of juice at 06.00am and 200mls of tea at 08.00am and no other fluids for the rest of the day. Another person's fluid intake chart recorded they last had a drink at 17.00pm and then nothing until 08.30am the following day. This was a consistent theme throughout the service. Fluids charts were not completed correctly nor were they calculated at the end of each day to assess how much fluid intake the person had received that day. Food charts also contained omissions and gaps. For example, one person's food intake chart only recorded what they had for breakfast and no other meals were recorded. This was a consistent theme throughout the service. Staff told us about how they supported people to eat and drink. For example, one staff member told us, "We have one person who is quite poorly but they are currently eating and drinking well which is good." After this feedback, we subsequently looked at this person's food and fluid chart. However, we found that documentation failed to reflect that they were eating and drinking well.

Failure to maintain accurate and complete records which demonstrates the level of care and support that people receive with food and drink is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The atmosphere during lunchtime was quiet and due to the care and support needs of people, the lunch time experience was stagnated. For example, people had their lunch at various times which the lunchtime experience was pro-longed. We found this has little impact on the quality of care and food that people received. The manager acknowledged that improvements could be made to people's lunchtime experience. The manager told us, "Supporting over forty people living with dementia can be a challenge and I plan to visit other care homes in the area to gain inspiration on how we can make positive improvements."

A dedicated chef was in post and we spent time with them in the kitchen. The service had recently had their environmental health inspection where they were awarded a level five award (highest level). Despite this award rating, we found that weekly cleaning schedules had not been maintained, kitchen cupboards were worn with exposed chipboard and the extraction hood was thick with dust and grease. We brought these concerns to the attention of the manager and registered provider who told us, "We plan to reinvent the kitchen and are aware of the shortfalls." We have identified this as an area of practice that needs improvement.

We recommend that the provider reviews their weekly cleaning schedules.

Guidance produced by Skills for Care advises of the importance on a strong, skilled and competent workforce. This was recognised by the registered provider and manager. The manager told us, "When I started, the staff really lacked the skills and knowledge needed to provide effective care. I've organised a rolling programme of training and completed a training needs assessment which considers gaps in staff knowledge." Staff had completed training on moving and handling, safeguarding and dementia awareness. Upcoming training included death and dying, nutrition and hydration and person centred care. Staff had also been supported to develop their skills and knowledge and were completing qualifications and diplomas in health and social care. Staff spoke highly of the training provided. One staff member told us, "It has improved so much since the new manager came here, there are several types of training going on now and I have regular supervision."

The manager and registered provider were dedicated to providing high quality effective dementia care. The registered provider told us, "I'm in the process of completing my master's degree in dementia care and we are really keen to follow best practice guidelines in terms of dementia care." Thought and consideration had gone into making the service dementia friendly. People had been involved in naming the corridors of the service to help promote orientation. The manager told us, "We have a poppy lane and the wall colour is painted pink for poppies. It really helps the residents with orientation. They often say I live at room (room number) poppy lane." A sensory room was in the process of being set up. The manager told us, "This will be lovely when it's finished. It will provide people with that sensory stimulation and we have also instilled sensory lights in the garden and music so when people sit outside, there is also stimulation."

An extensive programme of dementia training had been provided to staff. One staff member told us, "We've had the Care Home in Reach team providing a 16 week programme of training on dementia care. It was really helpful and I learnt a lot." Another staff member told us, "The training was really helpful; it provided us with additional tools we can use and the use of different techniques." The manager told us, "The training was amazing. They supported us with how we can support individual residents but also how we can support people living with dementia generally." A visiting relative told us, "My (relative) is living with vascular dementia and can be incredibly difficult at times. However, the staff are so patient and have worked with us to ensure they can remain living here. The staff are amazing and we have been desperate to keep them here."

People received effective care that met their healthcare needs. Effective management of people's healthcare needs means people can live long healthy, autonomous and fulfilling lives. The service had a treatment room where people could see the GP or district nurse in private. The GP also visited the service on a weekly basis and staff told us about the positive rapport they had built with the GP. Where healthcare professionals had provided advice, these were followed in practice. For example, one person's medicine had been discontinued. The GP had requested that staff monitor the person's blood pressure to monitor for any possible side effects following the discontinuation of their medicine. We saw this had been followed in practice.

Good

Is the service caring?

Our findings

There was a friendly, homely atmosphere and people were cared for by staff that were kind and caring. People and relatives praised the caring approach of staff and told us that they were well cared for. One person told us, "Staff are all very kind and caring. I go out into the garden for private time, I miss going to church so my vicar comes here. I can get up and go to bed when I like. I like my independence and my privacy and dignity are respected." A visiting relative told us, "Staff are very caring, we were fully involved in planning his care and we can visit whenever we wish. His dignity is respected and a doctor can easily be arranged."

At our last inspection in April 2016, the registered provider was in breach of Regulations 10 and 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the staff handover took place in the communal lounge and the confidentiality of people was not maintained. People's records were also not stored securely. An action plan had been submitted by the registered provider detailing how they would meet the legal requirements. At this inspection, we found improvements had been made and the registered provider is now meeting the requirements of the regulations.

People's records were now stored securely and access to confidential information was maintained. Care plans were now electronic and all computerised data was password protected to ensure only authorised staff could access these records. The daily staff handover took place in private to ensure people's confidential information was not disclosed in public areas of the service or where other people could hear the handover.

People were treated with kindness and compassion, as individuals, and it was clear from our observations that staff knew people very well. Staff made eye to eye contact as they spoke quietly with people; they used their preferred names and took time to listen to them. One person was walking along the corridor and became distressed, trying to open the front doors of the service. A staff member sensitively approached the person and asked if they were ok and if they would like to go to the lounge. The staff member then offered their hand and they walked off to the lounge together. Another staff member noticed a ladies cardigan was undone, so offered to do it up for them whilst talking about a story from their childhood which made the person laugh.

People's right to privacy was respected. People were assisted discreetly with their personal care needs in a way that respected their dignity. One relative told us, "I visit whenever I want to and I am always made to feel welcomed. Staff are caring and they respect her privacy and dignity. Her room is nice with fresh flowers I bring and family photos. She can also choose her clothes." One person told us, "They promote independence here, dignity is respected, and it is fine." Staff members told us how they upheld people's privacy and dignity. One staff member told us, "If using a hoist in the communal area, we always use the screen and fully explain the process to the person. We always ensure doors and curtains are closed when providing personal care." Assistance with continence care was provided in a kind, dignified and discreet manner. Staff discreetly asked people if they would like to go to the toilet by sitting down next to them and where required supported people to access the toilet.

Staff were observed interacting with people in a friendly manner and provided emotional support when needed. Guidance produced by the Alzheimer's society advises that people living with dementia can often experience difficulties with orientation around their home and in relation to time. During the inspection, we found that a number of people experienced confusion as part of their dementia. We asked staff how they managed this. One staff member told us, "It can really depend on the person. For some people where they ask for their parents, I may ask sensitively, how old are you? How old would your mum be? However, for some people, this approach would not work, so I may say, let's have a cup of tea while they wait and go along with their reality."

Guidance produced by Age UK advises on the importance pets bring to older people. Quinnell House recognised the importance pets bring to older people living in a care home. The manager told us, "We encourage any relatives that visit to bring in their pets and we also have pet therapy visiting. One person's got their pet here with them and that provides a great comfort to them." We spent time with this person and they told us how they appreciated the service letting them bring their pet. They commented that the idea of their pet going to a shelter upset them and they were glad to have their pet with them.

Staff celebrated people's successes and special events. On the day of the inspection, it was a 'resident's' birthday. Their family visited and provided cake for the staff and other 'residents'. During the afternoon, staff hugged and sang happy birthday while the person went round handing out cake.

People's differences were acknowledged and respected. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. One staff member said to one person, "I like your scarf, it is ever so stylish." Diversity was respected in regards to people's religion. People told us they regularly accessed the local church and that Quinnell House held regular services. On the day of the inspection, a local church service visited the service and people gathered in the lounge for the service which also included singing of hymns.

Guidance produced by the Department of Health advises that for many, 'a good death would involve being treated as an individual, with dignity and respect, without pain and other symptoms, in familiar surroundings and in the company of close family and friends. Too often, however, people with dementia receive undignified treatment and are ending their lives in pain.' End of life care plans were not consistently in place. The manager told us, "We are in the process of asking relatives and people to complete advanced care plans, but we acknowledge this can be a sensitive subject." The registered manager provided evidence of letters they had sent to relatives asking them to assist with the completion of advanced care plans. They told us, "We are making a concerted effort to review and implement end of life care plans but we are not there just yet."

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us that they felt staff were responsive to their needs. One person told us, "They help me when I need it." People confirmed they would not hesitate in raising any concerns with the manager. One person told us, "I know who to complain to but I have never needed to." Despite people's positive comments, we found areas of care which were not consistently responsive.

At our last inspection in April 2016, the registered provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the registered provider had not ensured that there were effective systems in place to provide people with full support that they needed. The delivery of care at times was task centred and the registered provider had not ensured that all information was provided in a format that was suitable for a person living with dementia. An action plan had been submitted by the registered provider detailing how they would meet the legal requirements. At this inspection, we found steps had been taken to drive improvement; however, these were not yet embedded into practice or sustained.

At the last inspection, we found the service was task oriented, rather than person centred. Guidance produced by Skills for Care advises that for a service to have a person centred culture, staff need to understand that 'each person has their own identity, needs, wishes, choices, beliefs and values. One size fits all does not work when it comes to providing care and support.' The manager told us, "We have made significant improvements but there is still a long way to go." We explored with staff what person centred care meant to them. One staff member told us, "We give them the best to make them comfortable; this could include one to one care. We get into the mind-set of the resident to understand them and communicate with them so that they understand. One resident can get agitated when supporting them to eat; this is usually because they want a drink. There are routines in the home but we always give residents the choice, for example, ask if they want to come out for mealtimes." Staff knew people well; however, we observed interactions which reflected that a person centred culture was not fully embedded. For example, one staff member commented, "It's nearly 16.30pm, time for the feeds."

People's needs were assessed prior to them moving into the service and this information was used to develop care plans. Improvements had been made since the last inspection. Nearly all care plans at the service were electronic and the manager had been holding care plan reviews with people and their relatives to explore if care plans were fit for purpose and if they remained effective and identified all of people's needs and how to meet those needs. Care plans covered a range of areas from communication, medication, mobility, personal care and continence. Care plans considered the assessed need, objective and action to meet that assessed need. One person's nutrition care plan identified they were at risk of choking and experienced difficulty with swallowing. The recorded actions included for 'staff to provide one to one assistance with eating and drinking, a pureed diet to be provided and to support (person's) head posture when eating and drinking.'

Personalised care planning is at the heart of health and social care. It refers to an approach aimed at enabling people to plan and formulate their own care plans and to get the services that they need.

Personalised care plans consider the person's past, their life story, their wishes, goals, aspirations and what's important for them when receiving care. The provider's electronic care planning system allowed for information on people's likes, dislikes, hobbies and interests to be recorded. However, we found this information had not been inputted. This information was available on people's traffic light hospital information booklet, however, this information had not yet been transferred onto people's electronic care plan. The manager had also taken the initiative to ask people and their relatives to complete, 'This is Me' booklet (tool for people with dementia that lets health and social care professionals know about their needs, interests, preferences, likes and dislikes). Relatives were in the process of returning these booklets which provided personalised information. It was clear steps were being taken; however, on-going work was required to ensure the care planning process was person-centred.

We recommend that the provider seeks guidance from a national source on the implementation of person centred care plans.

Guidance produced by Social Care Institute for Excellence advises that older people are particularly vulnerable to social isolation and loneliness owing to loss of friends and family, mobility or income. Social isolation and loneliness have a detrimental effect on health and wellbeing. Throughout the inspection, we identified a number of people who preferred to stay in their bedroom or due to health reasons stayed in their bedroom. Social isolation care plans were in place and the manager had implemented social isolation/prevention charts which reflected that people should be checked upon and have interaction every hour. However, despite these measures in place, we found documentation failed to evidence that the risk of social isolation was being prevented. For example, one person's social isolation care plan stated they should have one to one interaction from the activity coordinators. Documentation failed to confirm this took place. One person's social isolation/preventative chart had not been completed between the dates 23 January 2017 to 1 February 2017. We asked staff how they mitigated the risk of social isolation. One staff member told us, "The activity coordinators go in and provide one to one. We regularly go in to provide care but we don't have time to do things with people." Another staff member told us, "It does bother me a lot. I would like to see more stimulation for people in their rooms. It would be nice to spend more time with them. Personal care takes precedence. One lady likes classical music but sometimes her radio is switched to Heart FM. It is important to follow her wishes rather than our own." We brought these concerns to the attention of the manager. They told us, "This is a training and cultural issue as all interactions whether providing care or support to eat and drink, can be meaningful and reduce isolation. It is not just the job of the activity coordinators. This is something we will focus on."

Failure to mitigate the risk of social isolation is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

For people who enjoyed participating in group activities, a variety of activities were available. People spoke highly of the activity coordinators and the opportunity for social engagement. One person told us, "We like the activities, all of them." Another person told us, "I like the quizzes, they are quite fun." The provider employed two dedicated activity coordinators who worked throughout the service six days a week. Activities included; arts and craft, bingo, cooking, quizzes and movie nights. The service had a dedicated activity room where a range of puzzles and jigsaws were readily available for people to access. During the inspection, we observed a variety of activities. People were engaging in a cooking class and an arts and craft session where they were making wall decorations for their bedrooms alongside light exercise to music. Daily newspapers were delivered for people to leisurely read and soft music was playing along in the background. We spent time with one person who recognised one particular song and started to sing along.

At the last inspection, we found the registered provider's complaints policy was not on display in a format

that was accessible to people living with dementia. Improvements were in the process of being made. The policy had been updated and was on display, but was not displayed in a pictorial format. Despite this, people knew who to complain to. One person told us, "Yes I know who to complain to." A visiting relative told us, "Never had to make a complaint, staff always listen to you." The provider had not received any formal complaints since September 2016. Historic complaints had been addressed since the manager had come into post in September 2016. The manager told us, "There were ongoing complaints that I inherited, that had not been addressed, so I worked on those. I even visited one person and their family at home to address their concerns. As part of our care plan reviews, we have also added a complaint section, so if any family members have any niggles or concerns, we can address them." For example, one care plan review included comments from the family about out of date décor and furniture and we saw that action had been taken.

The manager and registered provider had identified how the managements of complaints could be improved and had ordered a 'you said', 'we did' board. The manager told us, "This will allow us to clearly demonstrate how we have acted on people's feedback and what we did about it."

Requires Improvement

Is the service well-led?

Our findings

People, friends and family described the staff of the home to be approachable and helpful and spoke highly of the new manager. One person told us, "Manager, on the whole I think she is very good, I have no concerns, I am so happy to have my pet here with me." Another person told us, "I know the manager; I see her a lot, no complaints at all here." One staff member told us, "The new manager is very supportive and a lot of positive changes have taken place since they've been in post."
Whilst all feedback of the management was positive and we could see that significant changes were taking place. These changes were not yet embedded into practice.

A registered manager was not in post. The previous registered manager had left and de-registered in September 2016. A new manager had been appointment and had been in post five months. They were in the process of applying to become registered manager.

At our last inspection in April 2016, the registered provider had failed to maintain accurate and complete records and the quality assurance framework was not consistently robust. An action plan had been submitted by the registered provider detailing how they would drive improvements. At this inspection, we found steps had been taken and improvements had been made. However, we found continued shortfalls in relation to accurate and complete records not being maintained.

Each person had a range of documentation in place, these included, food and fluid charts, repositioning charts, night time checks and topical medicines records. We found a range of discrepancies with people's topical medicines records. For example, one person was prescribed a cream which was to be applied daily. Documentation reflected it had not been applied between the 1 January 2017 to 9 January 2017 or between the 25 January 2017 to 1 February 2017. Another person was prescribed a cream that required application twice a day. We could see it was consistently applied once a day but not twice. On some topical medicine records, the prescribed cream was recorded but not the directions for use. This meant we were unable to ascertain if the cream was being applied in line with the prescribing instructions. Where people were assessed at high risk of skin breakdown, repositioning charts were in place. We found most people were repositioned in line with the assessed frequency recorded in their care plan. However, we found some shortfalls where documentation reflected that a person was not repositioned in over eight hours. For example, they received support to reposition at 23.53pm and not again until 09.50am the following day. Some people had air mattresses in place as a preventive tool to prevent the risk of skin breakdown. Monitoring charts were in place for staff to record that the setting of the mattress had been checked daily. However, recording for one person reflected that the setting had not been checked since the 1 February 2017 and for another person, staff had not completed the monitoring chart since 13 January 2017. We brought these concerns to the attention of the manager who was open and responsive. They told us, "Last week, I was going on about the fluid charts and the importance of documentation. We're trying to ascertain if it's a training need or if they don't feel supported. Ultimately we are trying to ascertain the root cause"

Throughout the inspection, staff told us how they supported people to re-position and what monitoring charts were in place. From our observations, we could see that people were getting the level of care

required. However, documentation did not support this. Failure to maintain accurate, complete and contemporaneous records is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Documentation was in place for the recording of incidents and accidents. This included the date, time, person and staff involved and details of the incident/accident. However, follow up information was not consistently recorded. For example, the steps taken to reduce any further incidents and accidents. One incident record dated 18 December 2016 identified that the paramedics were called as one person's blood sugar was extremely high. Future actions were recorded as, 'Waiting for what paramedics say?' The follow up actions were noted as, 'Paramedics still with person.' There was no information recorded on how to safely manage the person's blood sugars to prevent any future incidences of high blood sugars. The manager told us, "We haven't formally started auditing incidents and accidents yet to monitor for any trends, themes or patterns. However, I have been going through the incidents and accidents identifying where more information is required." We have identified this as an area of practice that needs improvement.

We recommend that the provider seeks guidance from a national source of the auditing of incidents and accidents.

The manager had a range of tools that supported them to identify shortfalls in the delivery of care and how improvement could be made. They undertook a variety of quality assurance audits which covered areas such as infection control, care plans, health and safety and hand hygiene. The manager told us, "I've been in post since September 2016. During this time, I've been working with the staff to make them feel supported and promote their level of understanding and skills. Although progress has been made, we have a long way to go. However, we are keen to make a positive difference. For example, we plan to implement a nutritional tool called 'reliance on care.' This is a tool whereby people who drink from an amber cup mean they need prompting with drinking. People who have a red cup mean they need full assistance with drinking. That visual prompt for staff will hopefully really help staff and clearly identify those who need assistance." The registered provider told us, "We have a deputy manager starting in March 2017 who will be a great help and really support us and the manager in getting Quinnell House to where it needs to be."

Systems were in the process of being developed to enable people, staff and relatives to provide feedback on the running of the service. Satisfaction surveys had been sent out to relatives and the manager was awaiting people's feedback. Care plan reviews were being held with people and their relatives which provided a forum for people to provide feedback. One relative told us, "We definitely feel more involved now." A resident and staff meeting had been organised and the manager had been holding one to one meetings with all staff members to gain their perspective and feedback. One staff member told us, "Since the new manager has been in post, there have been a lot of positive changes. We also have a lot more support now that the manager is in post." Another staff member told us "The new manager is very approachable. The environment is a lot more dementia friendly and all the changes have been good changes."

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The manager of Quinnell House had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

People spoke highly of the new manager and their leadership style. One staff member told us, "Staff morale has much improved. The new manager is very supportive, open and friendly." Another staff member told us, "The manager has been making a lot of positive differences and the changes are noticeable." The registered provider and manager told us, "We want to embed a culture of person-centred care and high quality care.

We are keen to make improvements and move away from the previous task centred culture and really empower staff to come forward with any concerns or worries they might have."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to provide care and treatment that was appropriate, meet people's needs and reflected their preference. Regulation 9 (1) (a) (b) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that staff were acting in accordance with the requirements of the Mental Capacity Act 2005 where a person was deemed to lack capacity to give consent. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to maintain accurate, complete and contemporaneous records in respect of each service user. Regulation 17 (2) (c).