Hampton Care Limited

Hampton Care

Inspection report

Upper Sunbury Road
Hampton
Middlesex
TW12 2DW
Tel: 0208 481 7070
Website: www.hamptoncare.co.uk

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

We inspected Hampton Care on 17 and 20 April 2015 and the inspection was unannounced. A previous inspection had taken place on 16 June 2014 where the home was found to have met the regulations we inspected.

Hampton Care is a care home with nursing providing accommodation and personal care for up to 76 older people. On the day of our visit there were 72 people living in the home. The premises are in the form of a large residential home with lifts to all floors, with nursing staff and facilities on all floors as well as ordinary domestic facilities.

At the time of inspection the home's manager was newly appointed and had submitted an application to the Care Quality Commission for registration. 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.

People's feedback about the safety of the service described it as good and that they felt safe.

Summary of findings

People were safe because the service had systems in place to protect them from, bullying, harassment, avoidable harm and potential abuse.

The service had a proactive approach to respecting people's human rights and diversity and this prevented discrimination that may lead to psychological harm. Staff protected people's dignity and rights through their interaction with people and by following the policies and procedures of the service.

The service managed the control and prevention of infection well. Staff followed correct policies and procedures and understood their role and responsibilities for maintaining high standards of cleanliness and hygiene.

There was a lack of consistency in the effectiveness of the care, treatment and support people received. This was reflected in what we found during the inspection and echoed in the feedback we received from some people and their relatives.

Management knew that staff needed training and support, and had put in plans to achieve this. However, this was not up to date for all staff and did not always cover the right areas to meet people's needs. This was demonstrated by shortfalls in the amount of supervision and appraisal staff received and the depth of training in areas such as dementia and person centred care.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which requires providers to ensure that staff are trained and supervised appropriately.

You can see what action we told the provider to take at the back of the full version of the report.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by the manager and acted on appropriately.

People at risk of poor nutrition and dehydration were sufficiently monitored and encouraged to eat and drink. The quality of the food was good, with people getting the support they needed and the choice that they liked.

People and relatives spoke positively about the caring attitude of the staff. People received care and support from staff who know and understand their history, likes, preferences, needs, hopes and goals. The relationships between staff and people receiving support demonstrated dignity and respect, and staff understood and responded to each person's needs in a caring and compassionate way.

This was supported by policies and procedures which emphasised the rights of people and developments in care planning which included people's life histories written from their own perspective, which enabled staff to work in a person-centred way.

People nearing the end of their life received compassionate and supportive care.

People described the responsiveness of the service as good. People received personalised care, treatment and support and were involved in identifying their needs, choices and preferences and how they are met. People's care, treatment and support was set out in a written plan that described what staff need to do to make sure personalised care is provided.

Care, treatment and support plans were seen as fundamental to providing good person centred care. The service was in the process of updating care plans and moving to a new computerised system which meant that all staff would be able to access these plans at any time. Care planning was focussed upon the person's whole life, including their goals, skills, abilities and how they prefer to manage their health.

The service protected people from the risks of social isolation and loneliness and recognised the importance of social contact and companionship. The service enabled people to carry out person-centred activities within the service or in the community and encouraged them to maintain hobbies and interests.

People and their relatives described the front-line staff as very good. However, after a period without a registered manager and with the current manager being in post for only three months there were mixed views from people, their relatives and staff about the culture of the home and the quality of leadership and communication between the service and people.

The new manager has reacted well to immediate problems within the service, such as ensuring the recruitment of permanent staff and updating systems and procedures. However, the provider did not have sufficient systems or processes in place to assess,

Summary of findings

monitor and improve the quality and safety of the services provided in the home, including the quality of the experience of people living in the home. We also found that the provider did not have sufficient systems or processes in place to enable them to seek and act on feedback people and others on the services provided in the home in order to evaluate and improve the service.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which requires providers to ensure that they have robust quality assurance systems in place.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People's feedback about the safety of the service described it as "good" and that they felt safe. The service had systems in place to protect people from bullying, harassment, avoidable harm and potential abuse.

Staff protected people's dignity and rights through their interaction with people and by following the policies and procedures of the service.

The service managed the control and prevention of infection well. Staff followed correct policies and procedures and understood their role and responsibilities for maintaining high standards of cleanliness and hygiene.

Good

Is the service effective?
The service was not always effective.

There was a lack of consistency in the effectiveness of the care, treatment and support people received. Whilst there was evidence of training and supervision for some staff, this was not consistent across the staff team.

The manager and some other senior staff understood the requirements of the Mental Capacity Act 2005, but this was not consistent for all of the staff who would need to understand it.

Staff who had been trained were able to explain how they asked people for consent, including people with varying degree of dementia and understood the importance of gaining people's consent.

Requires Improvement

Is the service caring?
The service was caring.

People and relatives spoke positively about the caring attitude of the staff.

People received care and support from staff who know and understand their history, preferences and needs.

Staff understood and responded to each person's needs in a caring and compassionate way. This was supported by policies and procedures which emphasised people's rights.

Good

Is the service responsive?
The service was responsive.

People received personalised care, treatment and support and were involved in identifying their needs, choices and preferences and how they could be met.

Care planning was focussed upon the person's whole life, including their goals, skills, abilities and how they preferred to manage their health.

Good

Summary of findings

The service protected people from the risks of social isolation and loneliness and recognised the importance of social contact and companionship. The service enabled people to carry out person-centred activities within the service or in the community and encouraged them to maintain hobbies and interests.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People and relatives were complimentary about the front line staff. However, there were mixed views from people, their relatives and staff about the culture of the home and the quality of leadership and communication between the service and people.

The provider did not have sufficient systems or processes in place to assess, monitor and improve the quality and safety of the services provided in the home, or to enable them to seek and act on feedback people and others on the services provided in the home in order to evaluate and improve the service.

Hampton Care

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 17 and 20 April 2015 and was unannounced.

The inspection team consisted of three inspectors, a specialist professional advisor and an expert by experience who was experienced in care for older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held on the service including previous reports, notifications and feedback from the public. During the inspection we observed care practice and tracked the care provided through looking at records, care plans and speaking to a variety of people.

We spoke with nine people and 12 relatives. We also spoke with the manager, training manager, chef and kitchen staff, as well as four nursing staff and 13 care staff. We looked at 16 care records and 14 staff records. We also looked at the policies and procedures of the home and spoke with the local Healthwatch team who had recently visited the home.

Good

Is the service safe?

Our findings

The majority of people we spoke with were positive about how safe they felt in the home. One person told us, "I'm in the right place. It's extremely good, The carers are a happy crowd. They are a well-integrated team". Another said that they were "very satisfied". Other comments included, "I live like a queen here" and "It's outstanding, exceptional".

One relative told us that they felt their relative was safe at the home. They told us, "If I did not think they were safe I would not have them here." Another relative said, "They've looked after (mum) very well; they have got mum's best interests at heart". Another relative said their mother had transferred from another home where the family were not happy with her care.

Some people were more cautious in their comments, with one person telling us that the home was "not bad", and one relative who said that there was nothing "drastically wrong or dangerous" but who felt that the care was good "because I come in every day".

We observed that when one person had closed their door in order to have a private conversation a member of the care staff knocked on the door after a while to enquire if everything was ok, indicating that staff were vigilant in monitoring people's care and safety.

Staff told us they had received safeguarding training and were able to describe different types of abuse and how they would report any abuse/allegation/safeguarding concern to the manager.

One senior carer we spoke with had a good understanding of safeguarding and how to protect people from abuse, although was unfamiliar with the correct terminology. When examples of bruising or new marks were used to illustrate the point the senior carer was able to describe the process. We spoke with a nurse about safeguarding and found again that with prompting they were able to describe actions to take in a safeguarding situation.

Records showed that training and updated training had not been completed for some time. The manager, who had been in post since January 2015, informed us that this was one of the areas identified during her initial audit. The manager was able to show us that she had initiated a training plan which identified recent training for some staff and planned training for other staff.

There were policies and procedures with regard to safeguarding. The manager had also provided a comprehensive guide to people living in the home called "Safe and secure at Hampton Care". This guide described the different types of abuse, outlined the homes commitment to individual's rights and included the home's procedures for acting on concerns about abuse or harassment. This document was written clearly and in large type and provided to each person.

We saw records of safeguarding issues which had been raised with the local authority and these confirmed that the home worked collaboratively with the local social services to keep people safe.

We observed staff who were friendly and polite, and supported people in a way which was respectful and maintained their dignity. For example, a care worker was seen to call for assistance from a resident's door as she couldn't leave the person unattended.

There was good interaction between staff and we saw that care staff asked the qualified nurse for help when appropriate.

The manager had recently completed a review of the home's emergency plan and had made recommendations to the Provider which included the purchase of emergency mats ("Albac mats") for the evacuation of bed restricted residents .

There was a policy on the use of restraint, which included restraint involving bed rails. This policy was clear that restraint should only be used in the interests of safety. At the time of inspection no one was subject to any restraint.

Staff had received some training in dementia and demonstrated sufficient awareness of people's needs and behaviours that enabled them to care for them in a safe manner. However, this was of a basic nature and the training manager provided evidence that further training in this area was to be provided, including enabling staff to sign up for qualification courses. The manager's audit to the provider included a recognition of the need for a senior care, or "unit manager" with experience in dementia, to be recruited.

Staff had received training on how to assess risks and we saw that people's care plans included risk assessments. These included risks associated with falls, nutrition, weight

Good

Is the service safe?

loss and use of the emergency call system. For example, one record noted the risk of injury if the person was not moved correctly. Staff were advised to use a sling hoist when moving the person.

Where it was appropriate to people's needs, risk assessments included the Waterlow and Malnutrition Universal Screening Tool (MUST) assessments and scores which had been updated monthly, although we saw one case where changes weren't always reflected by an updated care plan.

Other risk assessments included moving and handling, call bell assessments, continence, social and psychological care, communication, night care, pain management, nutrition, general physical care, environmental. There were body maps, consent forms for bedrails, personal care and end of life wishes.

The manager was able to provide evidence that record keeping and care plan updates had been included in her audit in January and that work was underway to improve the standard of record keeping and quality with regard to assessments and care planning. The new electronic system was not fully operational and only a few had data transferred across from old files. We advised the manager of the risk that data could be input from old files without reviewing the information which would simply result in a new system having out-dated information. The manager acknowledged this and told us that as training developed with staff this risk should be mitigated.

Accidents and incidents were recorded and appropriately signed by the nurse on duty in accordance with the procedures. We looked at a sample of 16 accident records, all of which had been recorded appropriately. Most of the accidents were of a minor nature and were the result of stumbling or falls and covered a wide number of people rather than the same person frequently.

The premises were clean and well maintained and equipment and hoists were clean. Domestic staff used colour coded cleaning equipment. The home kept a record of maintenance checks and any small repairs to equipment and there were up to date maintenance and audit logs of major items such as lifts and specialised beds.

The kitchen was of an industrial style and was clean and well equipped with staff appropriately dressed. Daily safety checks were seen for fridges and freezers and food temperature checks were all up to date. Kitchen cleaning was carried out by kitchen staff and a daily cleaning schedule on the wall was clear and up to date.

People told us they thought staffing levels in the home were good. One person told us that they felt the call bells were answered quickly but it was annoying to hear them sound. A relative thought there were fewer carers at weekends. Some other relatives said they thought there had been a bit of a shortage of carers in the night during January but the situation had improved recently.

One relative told us that although there were enough staff available to provide physical care and safety there was not much stimulation or person centred care and attention in practice and that at the weekend staffing levels could be low. Staff told us that there were generally enough staff especially on morning shift, although weekends and last minute absences could mean shortages.

During our inspection we observed staff attending to people in an unhurried manner. Staff supported people around the home and were attentive and patient, and supporting people according to their preferences.

We looked at staffing rotas for the week leading up to the inspection. There were different numbers of staff allocated to different floors or units and calculated according to the assessed needs of the people on these floors and that there was no different allocation of staffing on the weekend. Each shift was led by a registered nurse and supported by between three and five care workers. We noted that a review of staff allocation to floors and units was currently in progress and part of the audit carried out. The manager informed us that the owners of the home had not found any difficulty in accepting the findings of this internal audit.

One member of staff expressed concern that there was no clinical director. The manager informed us that a recruitment drive was currently in place and a deputy manager would be appointed who would act as the clinical lead in the home.

At the time of inspection there were interviews being prepared for the recruitment nursing staff and the manager was completing a process of reducing the amount of agency staff that had been used previously.

Good

Is the service safe?

We looked at a sample of staffing recruitment records. We saw that nurses had been recruited appropriately with Nursing and Midwifery Council (NMC) PIN numbers verified with no restrictions. The NMC regulates nurses and midwives in England, Wales, Scotland and Northern Ireland and exist to protect the public.

Staff files all showed evidence of criminal checks through the Disclosure and Barring Service (DBS), photo ID, application form and previous employment history. References had been followed up, Health declarations, signed job descriptions and contracts. There were policies and procedures in place relating to staff and their work and conduct.

We checked the medicines trolleys and the medicines administration record (MAR) charts. All blister packs were aligned as per the MAR charts. All bottles of medicines were dated when opened. Records of covert medicines were accurately kept. Covert administration of medicine is where medicine is given in a disguised form to individuals who are unable to give informed consent to treatment and refuse to take tablets/capsules or liquid preparations when they are offered openly.

The controlled drugs (CD) corresponded to the tally in the CD book. The home medicines books and running totals were aligned. We found that the RGNs, particularly on the top floor had a good knowledge of the safety issues behind medicines.

The service managed the control and prevention of infection appropriately. Staff followed policies and procedures and understood their role and responsibilities for maintaining high standards of cleanliness and hygiene. However, Policy and protocol folder on some units were very out of date, with some dating back to 2008. These issues had been highlighted in the recent audit under “Clinical Governance” and were being addressed.

Requires Improvement

Is the service effective?

Our findings

People's feedback about the effectiveness of the service was positive. One person told us, "The staff are all very kind. It's a higher level of care". A relative commented, "The staff have been exceptionally kind, her pressure sores have almost gone, they turn her regularly, everything is written down. She's in safe hands. They're very respectful.

We spoke with staff across all floors and areas of the home. One RGN told us they had started work at the home in 2014 and has received little additional training. This was corroborated by her personnel files. We saw that they had specifically requested the previous manager (who has since left) for robust continuous professional development at interview so that she could advance her practice, but that so far nothing has come to fruition.

We saw that training for staff was mixed. There was evidence of general, basic and mandatory training, including training in manual handling, adult protection, first aid, infection control, health and safety and mental capacity. One senior carer was actively undertaking dementia training via an online provider, but also told us that apart from this they hadn't had any other training other than end of life training since joining in 2010. The chef told us they had not had any training for "a long time" and that first aid and fire safety training were very out of date. Food hygiene and allergy training had been received "but a long time ago".

Staff told us most training was refreshed on a yearly basis and we saw a training matrix that evidenced this. However, there were areas of training that many staff had not yet undertaken, including food hygiene, dementia awareness, moving and handling and supervision and appraisal.

We saw that the new manager had begun to plan future training for staff and that records had been prepared which allowed identification of staff who required updated training. A training manager had been employed to focus on all staff mandatory training as well as improving training in the use of hoists, the new care standards and implementation of the Care Docs system of care planning and recording. This was at an early stage, having been introduced in January 2015.

Some staff told us they had supervision and appraisals, others said supervision and appraisals did not take place.

There were no records of supervisions and appraisals and the registered manager told us that she was arranging for staff to have appraisals because she did not believe they had taken place in the past.

There was no evidence of clinical supervision given by Registered General Nurses (RGN) to the carers and induction periods were not robust. One RGN spoke of a "shadowing period of two weeks". Two nursing staff had not had any supervision reviews and two care staff could not recall when they last had any reviews or appraisals.

We saw that people signed decision specific consent forms, for example, for consent to take a person's photo, bedrails and covert medicines.

Staff were able to explain how they asked people for consent, including from people with varying degree of dementia. One member of staff explained how a nonverbal resident used gestures and facial expressions to express their views and give consent. Staff we spoke with understood the importance of gaining people's consent.

Not all staff were knowledgeable about the requirements of the Mental Capacity Act 2005. The Mental Capacity Act (MCA) 2005 sets out what must be done to ensure the human rights of people who lack capacity to make decisions are protected.

Some staff were able to confirm that they had received training in the MCA and in the Deprivation of Liberty Safeguards (DoLS). DoLS requires providers to submit applications to a "Supervisory Body" if they consider a person should be deprived of their liberty in order to get the care and treatment they need.

An RGN was able to explain how DoLS related to protecting people's liberty. One member of staff did not understand the terms DoLS but did understand that the service could not restrict people's liberty.

However, other staff spoken to had very low awareness of deprivation of liberty requirements or what it comprised. One nurse said it meant offering choices and protecting people from abuse. Regarding mental capacity, none of the staff were able to provide any information on key principles.

This was corroborated by the training records compiled by the new manager. Records showed that around two-thirds of staff had received some training in MCA and DoLS between April 2014 and April 2015. Sometimes staff may

Is the service effective?

have attended two or three different courses on the same day, for example "Diversity and Equality", "Health and Safety" and "Fire". It was not clear from the information available how in-depth these courses were or whether they allowed time for exploring the application of training or were purely "awareness" sessions.

Although the newly appointed manager had begun arrangements to ensure all staff had mandatory basic training, there was insufficient evidence that all staff had received the same basic training or were all up to date with their training.

In addition there was insufficient evidence that staff had received more than "awareness" training in many areas, or that advanced training appropriate to the support needs of the people in home had been provided, such as person centred care, supporting people with dementia, DoLS, moving and handling theory and practice and end-of-life. Details of nursing training and review was similarly low. The supervision and appraisal systems were not sufficiently embedded in the organisation to ensure that staff at all levels received the appropriate level of supervision, including clinical.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records confirmed that people's capacity to make decisions was assessed before they moved into the home and on a daily basis thereafter. The manager had been trained in the general requirements of the MCA and DoLS and knew how it applied to people in their care. We saw records of two people for whom a DoLS authorisation had been requested and these had been correctly completed. The manager confirmed that on-going arrangements were in place to ensure all people who required a DoLS authorisation would have one made.

One person told us, "I love it here, and I like the food". Another said, "The food is fine. There is a selection and they've just introduced something hot for supper". One person told us that staff kept a careful watch to make sure he was taking in enough fluids.

Some relatives were not happy with the choice of food. One relative said, "The food isn't good, poor choice, why spaghetti bolognaise for older people- such a lot of waste." Another said, "So much is wasted- far too spicy, not what mum likes."

One relative described the food as 'diabolical', especially as the home claimed to have a 'luxury' service. However, this was not borne out during the inspection. We saw that meals were hot and nutritious. People had chosen from a menu and we saw that requests could be altered even at the last minute. The menu on the day included fish and chips, prawn salad, vegetable soup and apple crumble. On the various floors where people had lunch we observed staff attending to people and supporting them in a professional manner, and the atmosphere was pleasant and relaxed.

The hospitality staff were efficient in offering drinks and fluids when appropriate and were familiar with people's requests and needs.

Menus were displayed outside dining room showing the weekly plan and meal choices for each lunch and supper which were balanced and appropriate. Menus rotated weekly throughout the month. People could select their choice of meal the day before or in the morning although they could change their mind if they wished.

The kitchen was in the basement where all food was prepared from fresh by chef and up to 4 catering assistants. There were copies of the menu plans but kitchen staff were not given any advance information on food selected by residents. This made planning difficult and large quantities of food were wasted and had to be discarded. This appeared to reinforce the views of some relatives.

Kitchen staff did not know what happened when food left the kitchen and were not involved in staff or residents meetings so would not be aware of any discussions/ feedback with regard to menu planning except ad hoc suggestions which were conveyed verbally by staff. Kitchen staff expressed enthusiasm for more involvement in menu planning/information about individual needs.

People were positive about their access to healthcare services and their ongoing health support. One person told us, "A chiropodist comes every 6-7 weeks, a manicurist comes every week and a doctor comes every Wednesday." A relative said that the doctors who came to the home were very good and that their family member had been seen by a physiotherapist, a speech therapist and a dietician.

People experience positive outcomes regarding their health. Staff knew their routine health needs and preferences and consistently keep them under review. The service engaged proactively with health and social care

Requires Improvement

Is the service effective?

agencies and acted on their recommendations and guidance in people's best interests. Appropriate referrals were made to other health and social care services, for example care managers, tissue viability nurses, community psychiatric nurses, dentists and speech and language therapists.

We saw that four people required percutaneous endoscopic gastrostomy (PEG) feeding and one person had a tracheostomy. Care plans for these people showed that they were supported appropriately and dietician supporting advice was visible within each resident's room.

People were regularly weighed and records confirmed that if there were concerns about their weight they would refer them to a dietician or the GP.

Care plans contained an assessment of nutritional/ hydration status, and malnutrition universal screening tool (MUST) assessments were regularly updated (monthly). Although there was a nutritional care plan in all the files viewed they were not always legible or clear. For example one plan called for 'nutrition plan C' but there was no indication what this involved. There was a book with monthly weight monitors at the nurses station but this was not always reflected in care plans. One resident had 'no change' in monthly assessment although she had not been weighed since Jan 2015 according to the MUST screening form.

Premises were suitable for people and access to different floors was available by elevator. Each resident had a room with modern fittings and an en-suite toilet/washbasin. All rooms had call bells which were within reach of beds/ chairs. Some rooms were personalised with photos/ pictures/items of furniture. Bathrooms and toilets had suitable fittings and equipment for those with limited mobility and emergency cord pulls were accessible. There were communal lounges and dining rooms which were spacious and easily accessible for wheelchairs/other mobility aids.

On the floor which accommodated many people with dementia there was some evidence of improving the signposting for dementia residents and evidence of clustering of chairs to encourage communication and conversation. The manager showed us further plans for improving this area, including door furniture and reminiscence memorabilia.

Good

Is the service caring?

Our findings

People and their relatives were positive about the caring attitude of the staff. People received care and support from staff who know and understand their history, likes, preferences and needs. The relationships between staff and people receiving support demonstrated dignity and respect at all times.

One person told us, "The care is fine, it's reasonable. The carers I know are very pleasant, they speak to you."

A relative said, "Since [my relative] has been here the staff have been exceptionally kind. Pressure sores have almost gone, they turn her regularly, everything is written down. They are in safe hands. They're very respectful. The staff are all very kind. It's a higher level of care."

During the inspection we observed the interaction between staff and people and saw that staff knew people well and were caring and attentive. Staff were in colour coded uniform to indicate designation and all were wearing name badges to help people know their names.

We saw the Service Users Guide, which is a booklet provided to everyone. This gave clear and practical information about the home's services, and emphasised person centred care as part of its overall ethos. Care plans and other records which referred to people used language that was clear, respectful and person centred.

People were supported to express their views and staff were skilled at giving people the information and explanations they needed and the time to make decisions. The home had three activities organisers who were actively involved in working with people to ensure that their views about the service and the events and activities it offered met people's interests and needs. We saw that short summaries had been prepared for some people titled "This is me", which outlined a summary of the person, their interests and how they liked to be cared for in from a personalised viewpoint. Not everyone had a summary at the time of inspection as the staff were still in the process of completing these.

One person told us that they liked that fact that he could choose whether he had the door to his room open or closed. Another said that their care plan was reviewed once a year and now it was being reviewed once a month.

We received some concern from relatives regarding the continuity of care for those with dementia. One relative told us, "The manager has moved people around and at one stage there was a different nurse every day, although that had settled down a bit now". Another said, "It's important to have the same staff; you need faces you recognise if you have dementia. The only thing that worries us is that dementia nurses should be with dementia patients, so don't move them around; our mother recognises their voices."

Records showed that this had been the case due to the home reducing its dependency on long-term agency staff and the recruitment of new permanent staff. The manager informed us that the recruitment process was coming to a close and that this should improve the situation.

One relative commented that although staff were very nice they didn't engage much with residents or provide enough stimulation especially for those who were unable/unwilling to leave their rooms.

People were satisfied that they were treated with dignity and respect. In addition, relatives were happy with the way people were cared for. One relative said that the staff combed her mother's hair when they were about to feed her and said, "Little things like that make a big difference." Another told us that the staff kept her mother clean, that she was always in a clean nightdress, they washed her hair, and she liked the fact that there was no smell in the home.

Other relatives said, "The carers are great here, they're brilliant, the care has been wonderful. The staff are very receptive, and the night staff are very good. The carers have not just supported mum, but supported us over the years."

We observed that staff were caring, knew people's names and spoke with people in a friendly and respectful manner. Staff knocked on people's doors prior to entering their rooms and waited for a response before entering. People were not rushed when being assisted to move from bed to chair/ taken to toilets. Staff answered call bells/calls for attention promptly. We saw that people's rooms had their own pictures and furniture in rooms.

However, we also noted that interaction with people, although friendly and respectful, was often short and momentary, as most interaction tended to be functional and task-based. The activities staff ensured that more social interaction was provided and care staff made use of any opportunity they had.

Good

Is the service caring?

Care plans and records and daily reports discussed people in respectful language.

Policies inspected included policies on people's rights, dignity and privacy and confidentiality.

Person Centred care was part of the home's overall training programme as was dementia, although not all had completed recent Person Centred Care training and many still had to go on the dementia awareness training.

One resident on the top floor was receiving care at end of life and relatives had open access to the home and visiting their parent. The nursing records showed that care was given as per the care plan, for example, fluids via a syringe hourly and hourly repositioning. Carers were observed doing this and they carried out these tasks in a respectful manner. The atmosphere felt calm and carers were seen to ask questions of the qualified nurse who led the team with direction.

Care plans included sections on end of life preferences and wishes.

Good

Is the service responsive?

Our findings

People received personalised care, treatment and support and their care, treatment and support is set out in a written plan that describes what staff need to do to make sure personalised care is provided.

Two relatives told us that the staff always kept them informed of their mother's condition. One told us, "We are never made to feel we are interfering and they will listen to any suggestions. They do listen to you here; if we have an idea we talk to the nurse manager."

Care files contained a range of care plans linked to assessments and identified needs. These were colour coded to indicate high/moderate/low risk which made it possible to see where key areas of risk were for each person. There was a personal profile at the front of each care file with a photograph and details of name, date of birth/admission, medical conditions and contacts of Next of Kin)NOK), GP and other healthcare professionals. There were individual care plans for different aspects including general physical care, social/psychological needs, nutrition, night care, communication, as well as information on mental health, spiritual and cultural needs and end of life wishes.

Care plans contained sufficient detail on individual needs which included details of physical and health care needs, social interests, spiritual and cultural preferences. The home was in the process of transferring people's records to a computerised system and the progress of this varied from floor to floor. The manager was confident that the computerised system would eliminate the unwieldy and untidy nature of paper-based care plans.

The records showed that people's care records were updated by staff, but did not evidence that people were involved in updating plans. Staff said they reviewed care plans based on what they knew about people. Staff told us: "Some people's dementia makes it difficult to involve them in reviews, but we do involve family."

Staff were confident that they understood people's needs and could explain individual requirements and behaviour when asked. Staff were briefed verbally by the unit manager about people's needs and progress. There was a 'Life History' section in each care plan with information on background, family, hobbies/interests, with a copy in each person's room. This was a new initiative led by the activities officers in order to develop the person-centred approach and to make everyone more familiar with the personal histories of each person.

People were able to describe the various hobbies and activities they took part in. One person told us that they took part in the musical events, musical bingo and pottery. One person commented, "They do encourage you to do things." Another person told us that he went out of the home, and outings were part of the programme, such as the recent trip to the poppy factory.

However, two relatives expressed concern that despite their family members remaining in their bedrooms little stimulation was offered. We saw that many people were in their rooms or bedfast and staff interaction with them was mainly in attending to their care needs.

Activities organised in the home and schedule for current and next week were posted on the noticeboard. In addition the home had three activities officers who coordinated activities for care staff to participate in with people on each floor. One activities officer told us that they were aware of the need for greater interaction with people who were bedfast and that this was a challenge. However, activities had been included that could involve individual attention, such as newspaper articles on current affairs, beauty therapy and reminiscence. It was acknowledged that this was an area for further development.

The home had a complaints policy which was clearly stated and made available to everyone both in the service user guide and in the document "Safe and Secure". We looked at copies of complaints records and forms, including sections on following up the complaint and a complaint sign-off. Staff confirmed that they completed a form if any relative or resident complained.

Requires Improvement

Is the service well-led?

Our findings

People and relatives spoke positively about the efficient and caring way staff worked in the home. However, there were mixed views regarding the management and leadership of the service. This was partly a result of the recent arrival of a new manager, meaning people had not had much time to get to know them. In addition some rapid changes had been made which left many people anxious and frustrated and the lack of personal presence of the manager in and around the home and amongst people, had led to some people feeling there was a lack of leadership.

One relative told us, "The front line staff are great." They went on to say they felt the manager could be a bit distant, and "had not made an effort" to talk to relatives since they had been appointed. Another relative told us that the manager's manner was "a bit off-putting", although it had improved. They noted that the previous manager had been much more engaging with relatives.

We looked at how the service promoted a positive culture that was person-centred, open, inclusive and aimed at improving. The daughters of a resident said, "We went to meeting with the new manager who talked about cross training and we didn't know what it meant."

A person living at the home said they didn't know anything about residents' meetings, but said he looked forward to attending some in due course. Another relative told us that they were aware that the staff agency the home had been using had recently been changed, but they did not know why.

Some staff did not feel the organisation had been good at communicating with them. One staff member said, "I don't understand some of the changes, some things are just being changed because they were brought in by the older manager." One staff member said that the manager was not approachable and gave the impression that if staff were unhappy they could leave.

Other staff were positive about the manager and said they felt that she had brought in positive changes. One staff member told us, "To be fair, some of the changes she is making needed to have been made some time ago." An example of permanent staff recruitment was used to illustrate this. Another staff member told us, "She needs time to get an overview of the way things are. If you talk to her she does her best to support you."

Views about the improvements and communication by the home varied across floors, with the ground floor expressing more positive views from people, staff and relatives than the top floor, for example.

The manager confirmed there had been three general meetings and a system had been implemented which included unit meetings in the first week of the month and a clinical governance meeting in the last week of the month. This new structure had still to gel and take hold. A "Meet the manager" cheese and wine session had been held, but not many attended.

We found that the new manager, who had been in post for about twelve weeks had tried to implement some system of communication and meetings. However, this was still falling short of what people required, and there was little evidence of support or active involvement from the owners of the home during this transition period.

Interviews with staff indicated that the manager was not very visible in the clinical areas. There were emails attached to notice boards from her, but staff interviews revealed that she did not lead by clinical example.

We looked at quality assurance and how the systems and practices at the home sought the views of people and staff when reviewing the quality of the service and what learning they have achieved through carrying out audits within the service. We did not see evidence of active input or involvement by the providers either during the period where there had been a gap in management and the recent period where the manager had taken up post.

We saw that the manager had conducted an internal audit immediately on joining the service, which had resulted in a number of action plans. This was a positive start. However, this audit was focussed on immediate task-based improvements, such as updating mandatory training for staff, reviewing care plans, renewing staff supervision systems and meetings, health and safety records and equipment maintenance records. There had been no audit carried out by the provider which assessed or monitored

Requires Improvement

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the quality and safety of the services provided in the home (including the quality of the experience of people) or which sought the views of people, staff or relatives with the aim of evaluating and improving the service.

This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The manager was able to demonstrate that she understood her responsibilities under the Health and Social Care Act 2008 and was aware of the new regulations in place from 1 April 2015.

We saw that records were maintained and held securely. The home was going through a period of transition where they were computerising their records and this was progressing, although progress was varied across the floors.

Some staff have been enabled to participate in the Qualification and Credit Framework (QCF) as part of their professional development and the manager told us that the renewed systems of supervision and appraisal would help identify more development and training opportunities for staff.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not receive sufficient appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they were employed to perform. Regulation 18(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have sufficient systems or processes in place to assess, monitor and improve the quality and safety of the services provided in the home, (including the quality of the experience of people living in the home) Regulation 17(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have sufficient systems or processes in place to enable them to seek and act on feedback from relevant persons and other persons on the services provided in the home for the purposes of continually evaluating and improving the service. Regulation 17(2)(e)